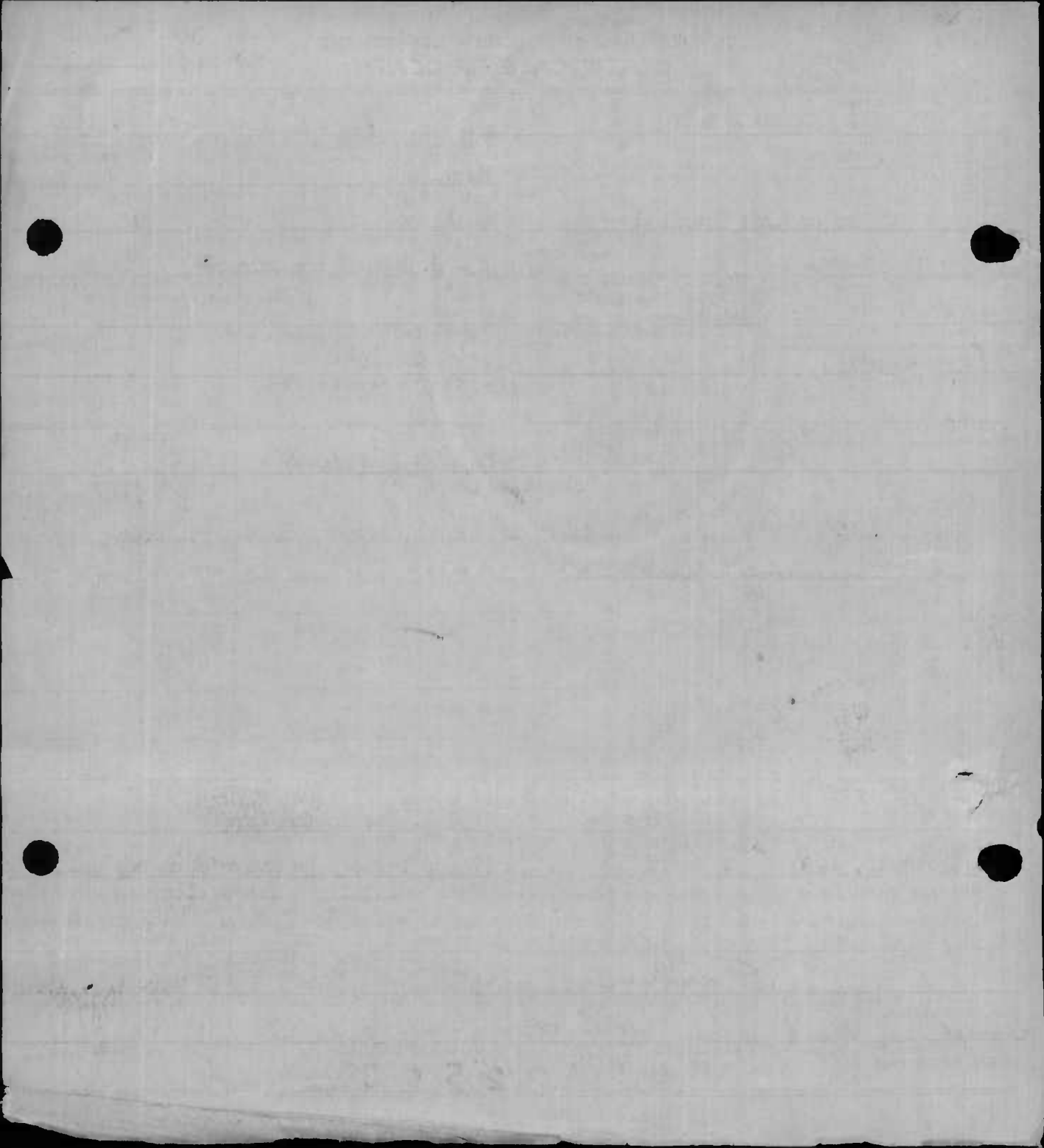


G-642  
50 2501BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2501  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MARY GORALSKI</b>		2. DATE OF DEATH <b>March 16, 1950</b>	
3. PLACE OF DEATH A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>237 S. Washington Street</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James Gorski</b>		ADDRESS	
18. <b>E9720 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxia due to carbon monoxide poisoning</b> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. TIME (Month) (Day) (Year) (Hour) <b>March 16, 1950</b>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>237 S. Washington Street</b>		21D. HOW DID INJURY OCCUR? <b>Three burners on stove open but unlit</b>	
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <b>R. S. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	
23C. DATE SIGNED <b>March 17, 1950</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 20/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25. FUNERAL DIRECTOR <b>W. J. Wrasidlo</b>		ADDRESS	











UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

My dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing artificial silk.  
The Bureau of Plant Industry is at present engaged in a study of the various methods of producing artificial silk, and it is hoped that the results of this study will be of assistance to you in your work.  
Very respectfully,  
J. H. H. H.

Very truly yours,  
J. H. H. H.



W-300

50 2503

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2503

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>COLEMAN Ruth A Wood</b>			2. DATE OF DEATH <b>193077 MAR 17 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore City</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Homeland - Baltimore, Md.</b>		
c. Length of stay in Baltimore <b>48 years</b>			D. STREET ADDRESS (If rural, give location) <b>203 Tunbridge Road</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>6-20-92</b>		9. AGE (In years last birthday) <b>57</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>New Oxford, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles H. Coleman</b>			14. MOTHER'S MAIDEN NAME <b>Martha J. Goebrecht</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b> ADDRESS		

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. <b>175 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer ovaries, multiple metastases</b>	(A) <b>metastases</b>	<b>5 mos.</b>
DUE TO		
(B)		
DUE TO		
(C)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-2-** 19**50** to **3-17-** 19**50**, that I last saw the deceased alive on **3-17-** 19**50**, and that death occurred at **5:00** a.m., from the causes and on the date stated above.

23A. SIGNATURE <b>Joseph King</b> M.D.	23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	23C. DATE SIGNED <b>3-17-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	24B. DATE <b>Mar-20-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 19 1950</b>	REGISTRAR'S SIGNATURE <b>5 0 0</b>	25. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co., 108 W. North Ave.</b>	







F. 460

50 2504

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2504  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Henry Fowler

2. DATE  
OF  
DEATH

3-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3106 Ferndale Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give town ship)

BALTO -

MD -

28-02

D. STREET ADDRESS (If rural, give location)

3106 - FERNDALE AVE -

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

1-23-1880

9. AGE (In years last birthday)

70

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Furniture

11. BIRTHPLACE (State or foreign country)

Baltimore Md,

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Henry Fowler

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

219-28-3208

17. INFORMANT

ADDRESS

Mary Elizabeth Fowler

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(see over)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH 3106 Ferndale Ave.

(A) Cerebral Hemorrhage

DUE TO

(B) Chronic glomerulonephritis

DUE TO

(C) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

6 hours

2 years

10 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 11, 1950, to Feb 21, 1950, that I last saw the deceased alive on Feb 21, 1950, and that death occurred Feb 21, 1950, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3-20-50

Loudon Park

Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 19 1950

E. J. Annacost  
5118 Gwynn Oak Ave.

VS 150

29867

131a

MEDICAL CERTIFICATION



3/18/50

At the time of Mr. Fowlers death, the undersigned was out of the city, and the man was pronounced dead by Dr. H. V. Harper, 5201 Gwynn Oak Avenue, Balt. 7, Md. This fact has been communicated to Dr. Fisher, the Medical Examiner.

M. T. Kraly, M.D.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Adolph Volkman**

2. DATE  
OF  
DEATH

**3/18/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

**1226 Cleveland St.**

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE  
**Md.**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**1226 Cleveland St.**

5. SEX

**Male**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED,

**Married**

8. DATE OF BIRTH

**Sept. 29, 1880**

9. AGE (In years last birthday)

**69**

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Retired Blacksmith**

10B. KIND OF BUSINESS OR INDUSTRY

**B. & O. R. R.**

11. BIRTHPLACE (State or foreign country)

**Germany**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Volkman**

14. MOTHER'S MAIDEN NAME

**Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Mrs. Augusta Volkman, 1226 Cleveland**

**CAUSE OF DEATH**

18. **422.2**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

**16 months**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Mar 8<sup>th</sup>, 1950** to **Mar 18, 1950**, that I last saw the deceased alive on **Mar 17, 1950**, and that death occurred at **5<sup>th</sup> A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

**Harry G. Bates, M. D.**

23B. ADDRESS

**517 Scott St.**

23C. DATE SIGNED

**3/18/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**3/21/50**

24C. NAME OF CEMETERY OR CREMATORY

**St. Paul's Cemetery**

24D. LOCATION (City, town, or county) (State)

**Violetville, Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

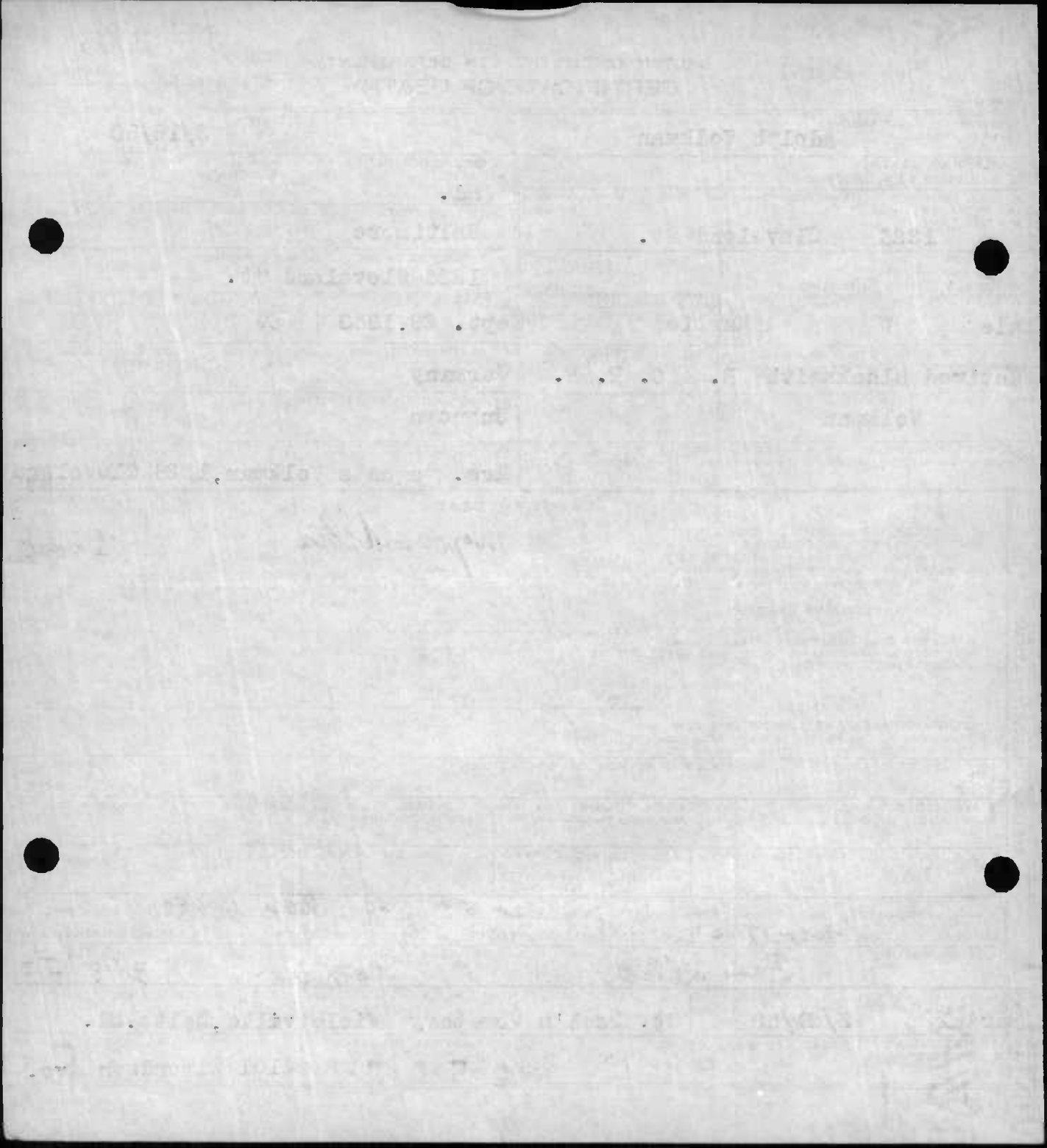
ADDRESS

**Mar 18 1950**

**Mar 18 1950**

**Harry G. Bates 4101 Edmondson Ave.**







D-552  
50 2506BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2506  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas L. DOWNING

2. DATE  
OF  
DEATH

Mch 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

West Batts General Hosp.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Batts.

2001

D. STREET ADDRESS (If rural, give location)

531 N. Bruce St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 12, 1873

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

B. &amp; O. P. R.

11. BIRTHPLACE (State or foreign country)

N. C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Arthur Downing

14. MOTHER'S MAIDEN NAME

Virginia

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

705-07-2130

17. INFORMANT

ADDRESS

Celara M. Downing, 531 N. Bruce St.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Thrombosis Inferior Cerebellar Artery

32 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Cardio-vascular disease

unknown

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-14-50, 19, to 3-17-50, 19, that I last saw the  
deceased alive on 3-17, 1950, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Sheen

M. D.

23B. ADDRESS

W 422.1

23C. DATE SIGNED

3-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/20/50

24C. NAME OF CEMETERY OR CREMATORY

Lauraine Pk.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 19 1950

1-4 5 0 0

Harry N. Ditzel, 4101 Edmondson Ave

VS 150

937

MEDICAL CERTIFICATION

correct age is especially important



DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

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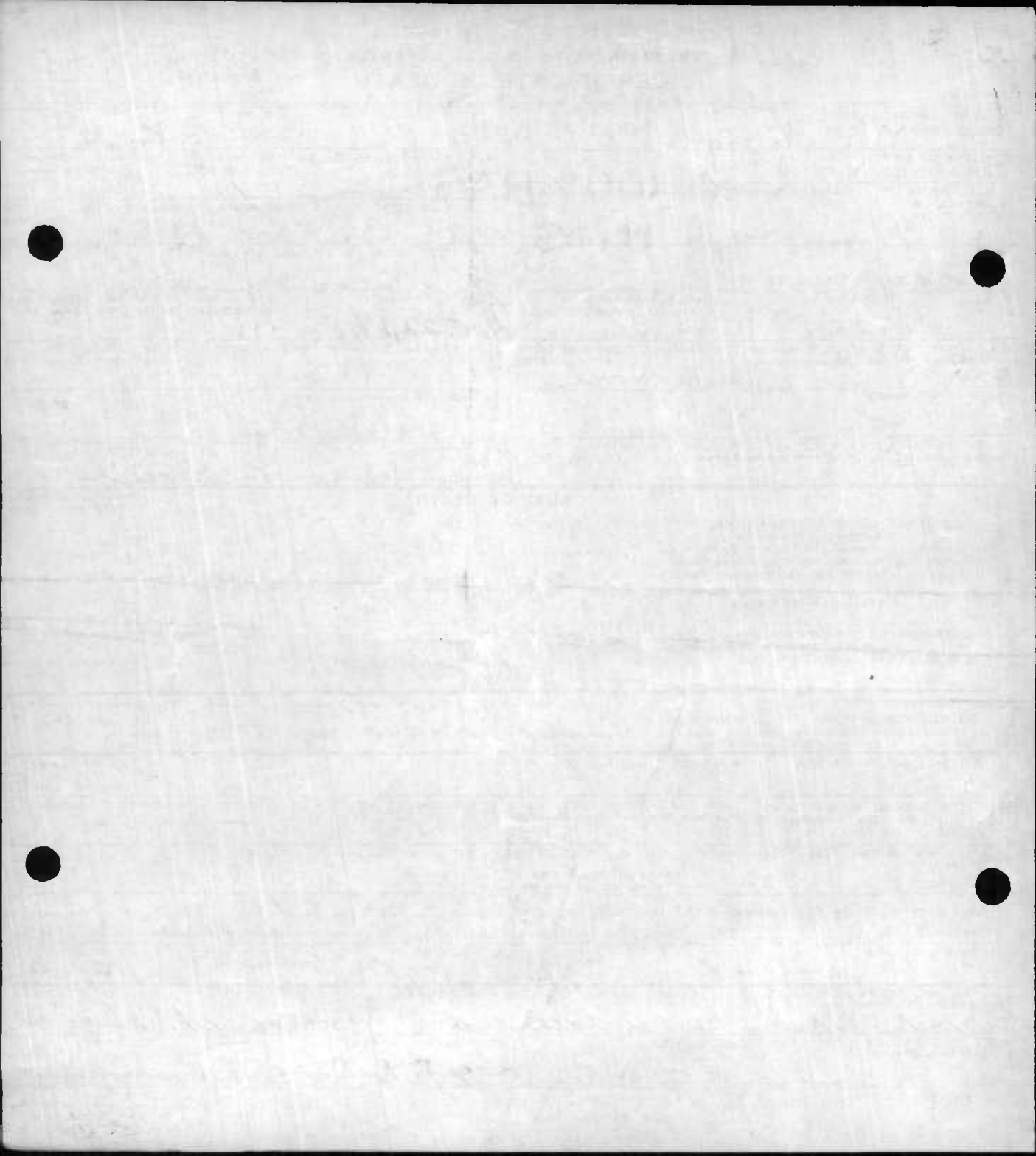


J-535  
50 2507BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2507  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Nellie V. Johnson</i>		2. DATE OF DEATH <i>3/16/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes Hospital Balto Md</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>520</i>	
6. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>823 Braeside Road.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Nov. 22, 1918</i>
9. AGE (In years last birthday) <i>31</i>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Fred Holt Schneider</i>		14. MOTHER'S MAIDEN NAME <i>Marriett Deal.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Chas. E. Johnson, 823 Braeside Rd.</i>		ADDRESS	
18. <i>170X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>CAUSE OF DEATH</i> <i>METASTATIC CARCINOMA LUNGS</i> (A) ..... DUE TO <i>CARCINOMA LEFT BREAST</i> (B) ..... DUE TO ..... (C) ..... INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION	
20. MAJOR FINDINGS OF OPERATION		21. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>METASTATIC CARCINOMA SPLEEN, METASTATIC LUNG NODES</i>		23. DATE OF OPERATION	
24. DATE OF OPERATION		25. MAJOR FINDINGS OF OPERATION	
26. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		27. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29. HOW DID INJURY OCCUR?	
30. TIME (Month) (Day) (Year) (Hour) OF INJURY		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
32. I hereby certify that I attended the deceased from <i>2/21</i> , 19 <i>50</i> , to <i>3/10</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/10</i> , 19 <i>50</i> , and that death occurred at <i>11</i> a. m., from the causes and on the date stated above.			
33. SIGNATURE <i>[Signature]</i>		34. ADDRESS <i>St. Agnes Hospital</i>	
35. DATE SIGNED <i>3/16/50</i>		36. M. D.	
37. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		38. DATE <i>Mar. 20/50</i>	
39. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		40. LOCATION (City, town, or county) (State) <i>4300 Old Trust. Rd. Balto. Md</i>	
41. DATE RECEIVED BY LOCAL REGISTRAR		42. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
43. FUNERAL DIRECTOR <i>Edmondson</i>		44. ADDRESS <i>4101 Edmondson Ave</i>	







600  
50 2508BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2508  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Muir, Charles

2. DATE  
OF  
DEATH

3-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

36 Franklin Square Hospital

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Baltimore 16-01

D. STREET ADDRESS (If rural, give location)

1037 Harlem Ave

5. SEX

Male

6. COLOR OR RACE

Col

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept. 15, 1869

9. AGE (In years  
last birthday)

80

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

US

13. FATHER'S NAME

none given

14. MOTHER'S MAIDEN NAME

none given

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital record

18. 151X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of stomach

6 mos

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-14 1950, to 3-16 1950, that I last saw the  
deceased alive on 3-16 1950, and that death occurred at 8:55 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. F. Hawkins, Jr.

M. D.

23B. ADDRESS

Franklin Square Hotel 3-16-50

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/19/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem. Brooklyn NY

24D. LOCATION (City, town, or county) (State)

Brooklyn NY

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. F. Hawkins, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Eugene Wilson 1000 Brantly ave

ART 1950

46B



MINUTE OF THE BOARD OF DIRECTORS  
CENTRAL BANK OF DENMARK

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623

50 2509

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50 2509

1. NAME OF DECEASED (Type or Print) <i>Ellen W. Wright</i>		2. DATE OF DEATH <i>March 16, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. City</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 12-07</i>	
C. Length of stay in Baltimore <i>25 Yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>2105 N. Howard St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 1, 1900</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>49</i>
11. BIRTHPLACE (State or foreign country) <i>Oak City N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Calvin Ebron</i>		14. MOTHER'S MAIDEN NAME <i>Roxann Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. *443 X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) *Hemorrhage from Left Middle Cerebral Artery*  
DUE TO  
(B) *Hypertensive Cardiovascular Disease*  
DUE TO  
(C) *Chronic Duodenal Ulcer*

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <i>3-16</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *3-16*, 1950 to *3-16*, 1950 that I last saw the deceased alive on *3-16*, 1950, and that death occurred at *7:25 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>David A. Wilson</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>3-17-50</i>
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/20/1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Brooklyn A.A.Co.Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Elroy O. Wilson</i>	25. FUNERAL DIRECTOR ADDRESS <i>1000 Brantly Ave</i>	

*MAR 20 9 1950*  
*117B*

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1900

STATE OF NEW YORK

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATIONS

DIAGNOSIS

TREATMENT

PROGNOSIS

REMARKS

SIGNATURE

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PLACE

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2510  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Joe Williams</b>		2. DATE OF DEATH <b>3/15/1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1216 Madison St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore City 10-02</b>	
D. STREET ADDRESS (If rural, give location) <b>1216 Madison St</b>		E. LENGTH OF STAY IN BALTIMORE <b>10 Yrs.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>12/24/1920</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bond Baking Co.</b>	
13. FATHER'S NAME <b>Rufus Williams</b>		14. MOTHER'S MAIDEN NAME <b>Unkown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Unkown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth Williams</b>		ADDRESS <b>1216 Madison St</b>	

18. <b>DOX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pulm. tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

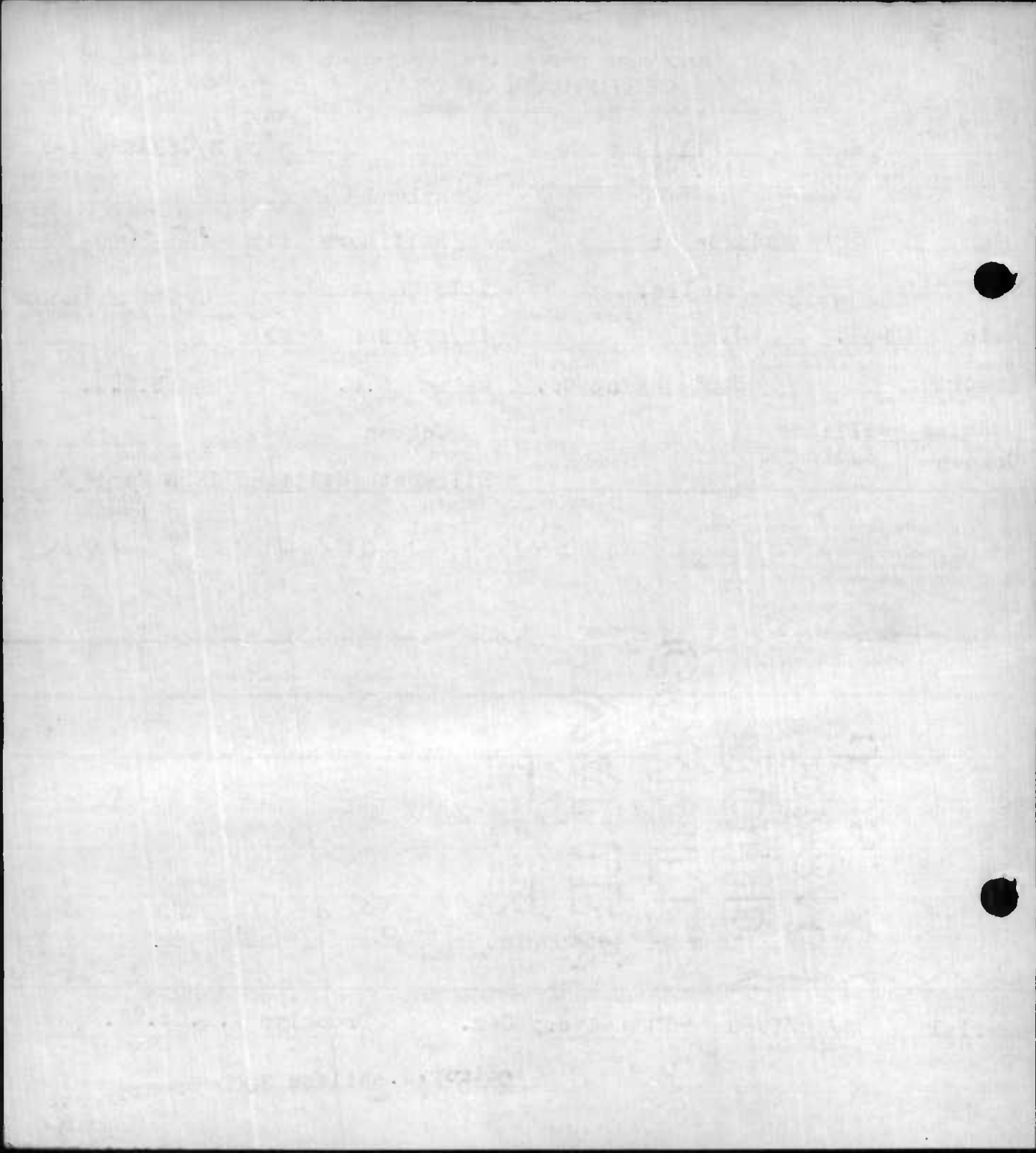
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

2. I hereby certify that I attended the deceased from **2-22**, 19**50**, to **3-15**, 19**50** that I last saw the deceased alive on **3-7**, 19**50** and manner occurred at **1500 EAST MADISON ST. BALTIMORE**, from the causes and on the date stated above.

23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <b>1500 EAST MADISON ST. BALTIMORE</b>		23C. DATE SIGNED <b>3-15-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/20/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvery Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn A.A.Co.Md.</b>		25. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>		ADDRESS <b>1000 Brantly Ave</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		VS 150 MAR 19 1950 <b>750XV</b> <b>13B</b>	

MEDICAL CERTIFICATION







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 2511**

**320**  
**50 2511**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MEADOWS, ALMA TIMOTHY</b>		2. DATE OF DEATH <b>3/19/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>The Rocks</b>	
D. STREET ADDRESS (If rural, give location) <b>—</b>		Yrs. Mos. Days	
Length of stay in Baltimore <b>UNK</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>1/30/1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER, FARMER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	9. AGE (In years last birthday) <b>62</b>
11. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE MEADOWS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>WIFE (LOTTIE MEADOWS)</b>		ADDRESS <b>SAME</b>	

18. <b>523.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>FEVER OF UNKNOWN CAUSE (TO BE DETERMINED BY BACTERIOLOGY)</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) DUE TO	
	(B) DUE TO	(over)
	(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3/11**, 1950, to **3/19**, 1950, that I last saw the deceased alive on **3/19**, 1950, and that death occurred at **4:05** A. M., from the causes and on the date stated above.

23A. SIGNATURE **J. Frank Supple, III** M. D. 23B. ADDRESS **Union Memorial Hosp.** 23C. DATE SIGNED **3/19/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/22-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>odd W va</b>	24D. LOCATION (City, town, or county) (State) <b>Bald W Virginia</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>	REGISTRAR'S SIGNATURE <b>William H. Williams</b>	25. FUNERAL DIRECTOR <b>Martha G. Smith</b> <b>Jane Howell med</b>	

MEDICAL CERTIFICATION



See Document File 50-2511

3/27/51

ES



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2512

Registered No. \_\_\_\_\_

BIRTH NO. 50 2512

1. NAME OF DECEASED (Type or Print) <b>JAMES A. PHIPPS</b>			2. DATE OF DEATH <b>March 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>1927 McHenry St.</b>			6. STREET ADDRESS (If rural, give location) <b>1927 McHenry St.</b>		
7. SEX <b>Male</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	10. DATE OF BIRTH <b>Apr. 14, 1883</b>		11. AGE (in years last birthday) <b>66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Odd Fellows Temple</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <b>James Phipps</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Atwell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Laura M. Phipps, 1927 McHenry St.</b>		

18. <b>002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>—</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>—</b>		

19A. DATE OF OPERATION <b>3-18-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>—</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>—</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I hereby certify that I attended the deceased from <b>March 18, 1950</b> to <b>3-18, 1950</b> that I last saw the deceased alive on <b>3-17, 1950</b> and that death occurred at <b>7:30 A. M.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>William B. Schriber, M.D.</b>		23B. ADDRESS <b>54 S. F. Altam Ave.</b>		23C. DATE SIGNED <b>3-18-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/21/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Trinity</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		REGISTRAR'S SIGNATURE <b>William B. Schriber</b>		25. FUNERAL DIRECTOR ADDRESS <b>William Cook, Inc., 1217 St. Paul St.</b>	

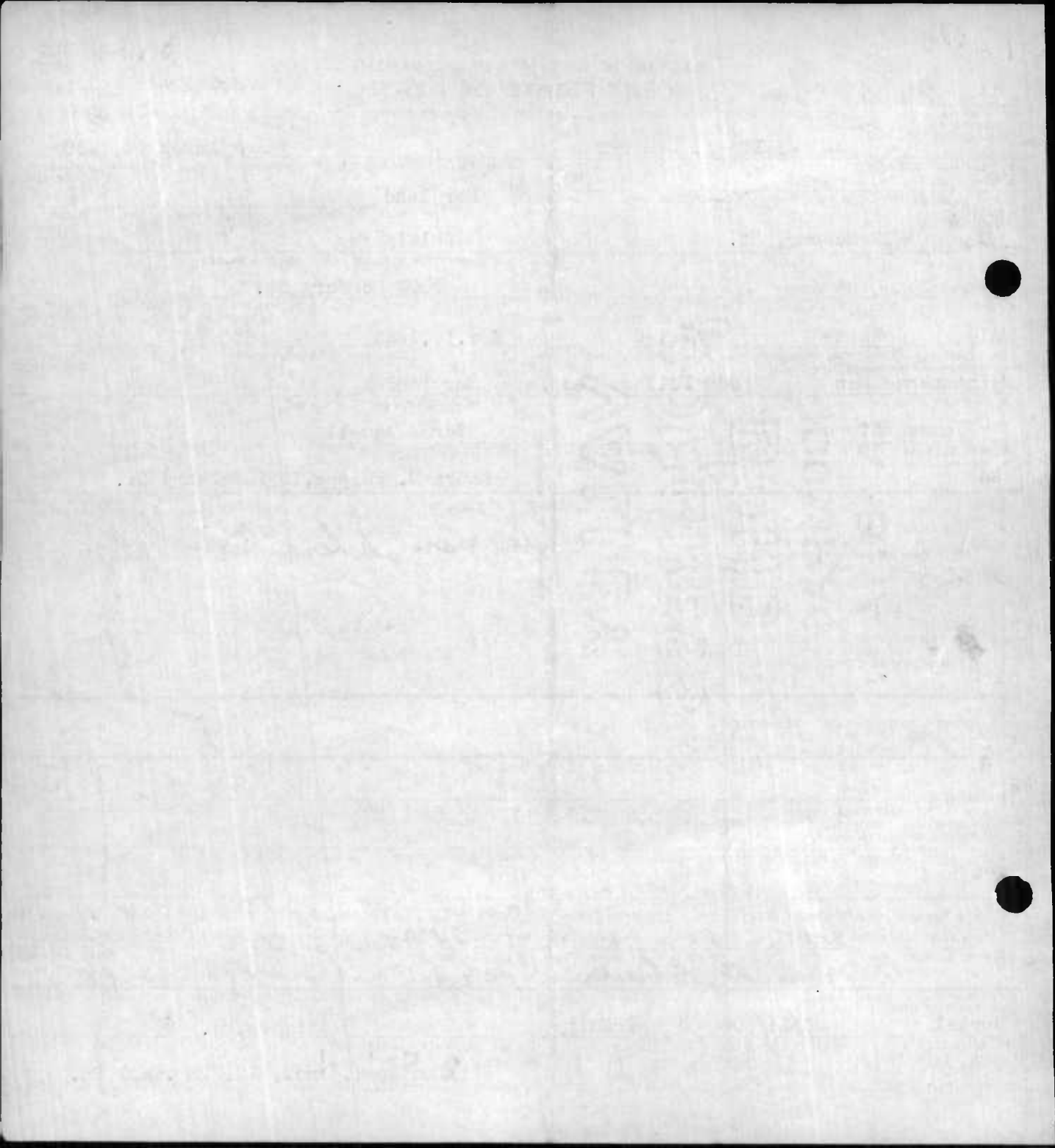
33694

13B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2513  
Registered No. 50 251350 2513  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAY D. FOX		2. DATE OF DEATH Mar. 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1808 Thomas Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-03	
D. STREET ADDRESS (If rural, give location) 1808 Thomas Ave.		8. DATE OF BIRTH 1879	
5. SEX Female		9. AGE (in years last birthday) 70	
6. COLOR OR RACE White		If Under 1 Year Months: Days If Under 24 Hours Hours: Min	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME (Unknown) Ward		12. CITIZEN OF WHAT COUNTRY? ✓	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William V. Taylor, 1808 Thomas Ave.	

18. 191X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) Lobar Pneumonia DUE TO (B) Epithelioma of Nostril DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 2 days I
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

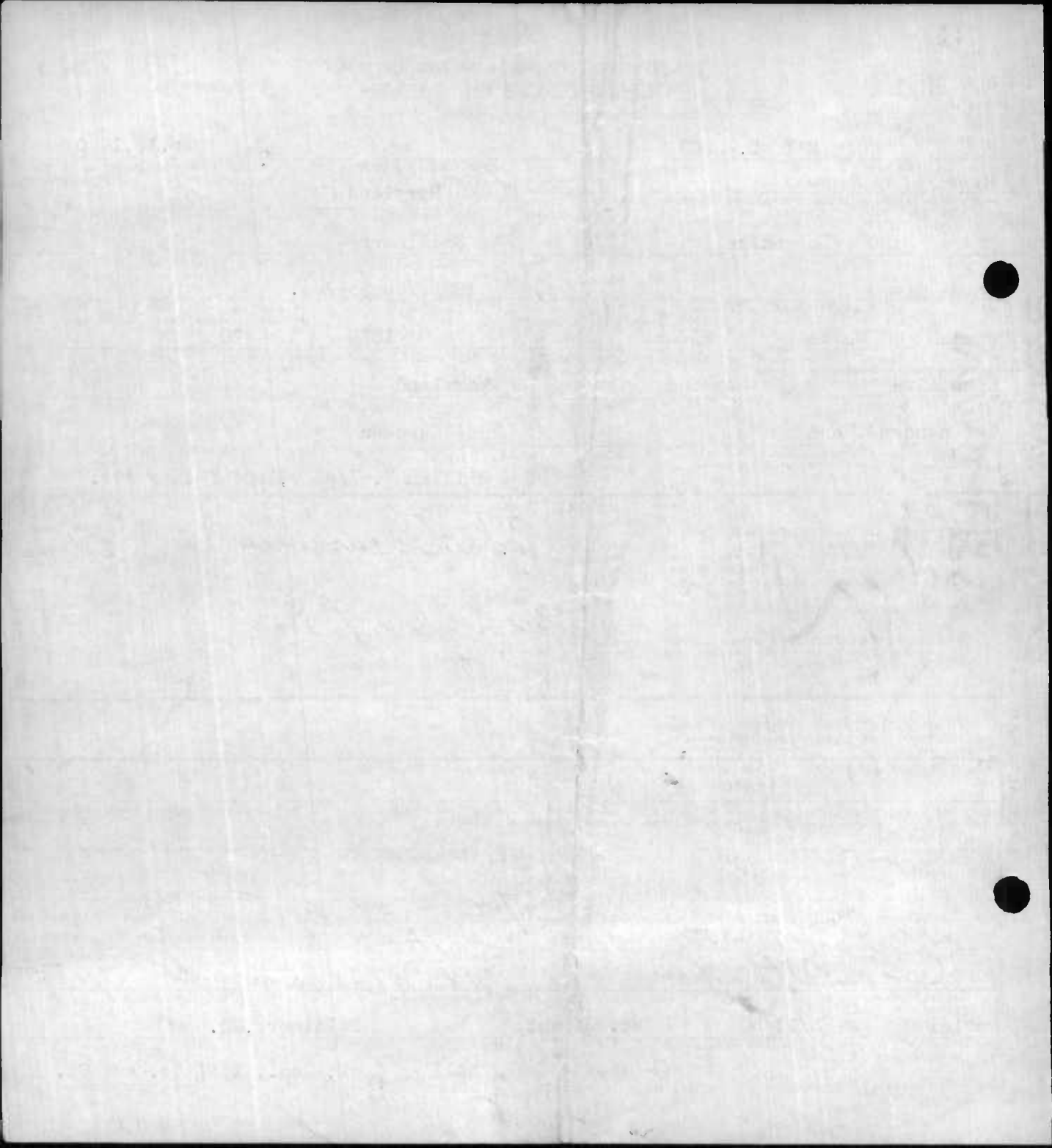
22. I hereby certify that I attended the deceased from 3/17, 1950, to 3/18, 1950, that I last saw the deceased alive on 3/17, 1950, and that death occurred at 7A m., from the causes and on the date stated above.

23A. SIGNATURE  
Charles W. Cullen M. D.  
23B. ADDRESS  
2145 W. Baltimore St.  
23C. DATE SIGNED  
3/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/21/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
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DATE RECEIVED BY LOCAL REGISTRAR MAR 20 1950	REGISTRAR'S SIGNATURE William V. Taylor	25. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St.
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620

50 2514

## BALTIMORE CITY HEALTH DEPARTMENT

50 2514

## MARTIN CERTIFICATE OF DEATH

Registered No.

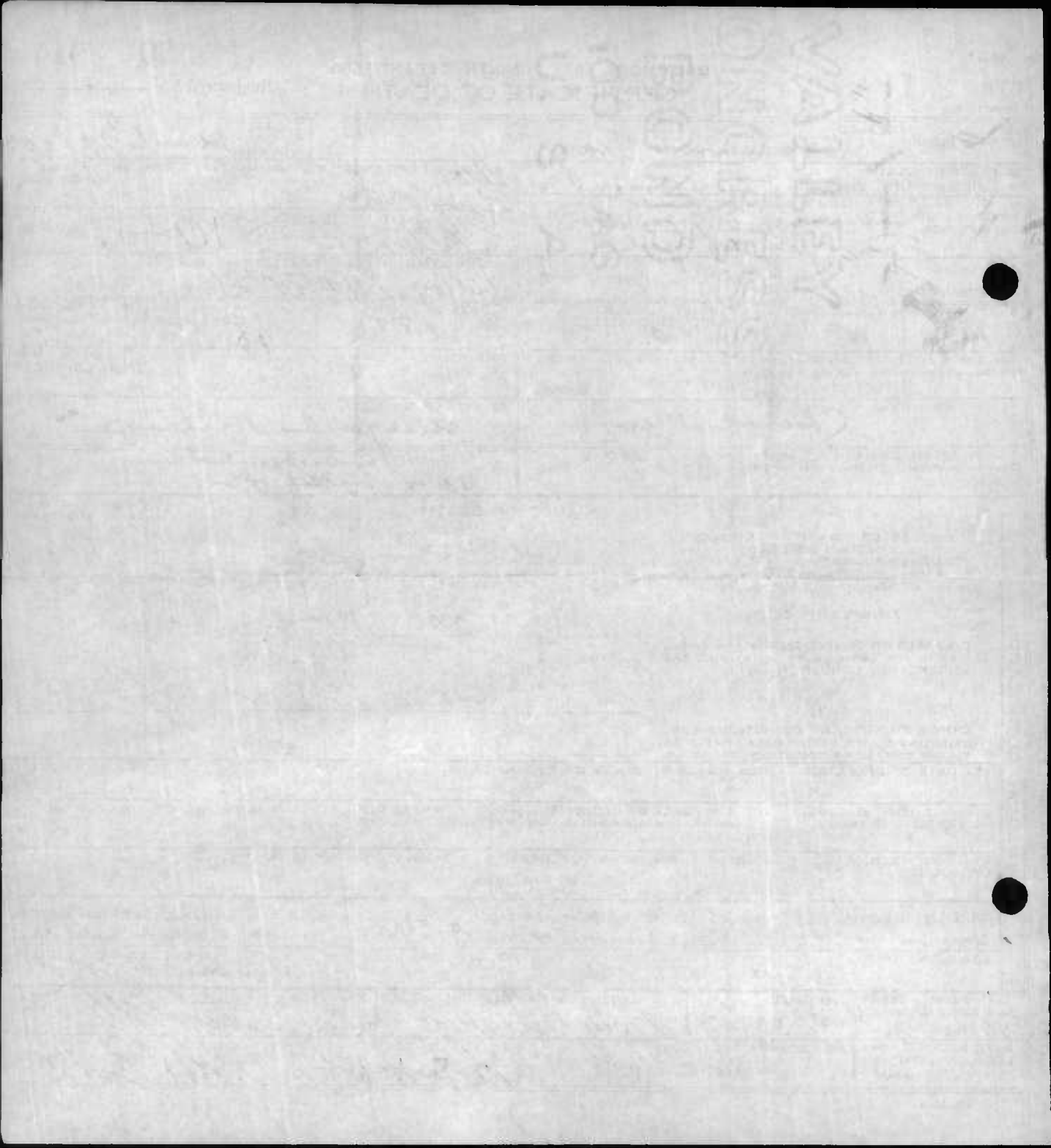
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Martin Mary</i>		2. DATE OF DEATH <i>March 19/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) B. COUNTY <i>10-01</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Home for the Aged</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
5. SEX <i>M.</i> 6. COLOR OR RACE <i>W.</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>		D. STREET ADDRESS (If rural, give location) <i>Valley Industry St</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CABINET MAKER</i>		11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY <i>USED FURNITURE</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Conrad Mary</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Triller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Dr. J. J. J. J.</i>		ADDRESS <i>1201 Valley St.</i>	

16. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Edema Lungs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) DUE TO		<i>Chronic Myocarditis</i> <i>3 yr</i>	
		(C) DUE TO		<i>Arterio Sclerosis</i> <i>5 yr</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 1 -</i> , 19 <i>50</i> , to <i>March 19</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>March 18</i> , 19 <i>50</i> , and that death occurred at <i>9:20 PM.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>E. G. Hall M.D.</i>		23B. ADDRESS <i>1631 E. North Ave</i>		23C. DATE SIGNED <i>March 19 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>3/22/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>		24E. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		24F. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 20 1950</i>		REGISTRAR'S SIGNATURE <i>W. J. J. J.</i>		25. FUNERAL DIRECTOR <i>W. J. J. J.</i>	
				ADDRESS <i>1201 Valley St.</i>	







50 2515

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

50 2515

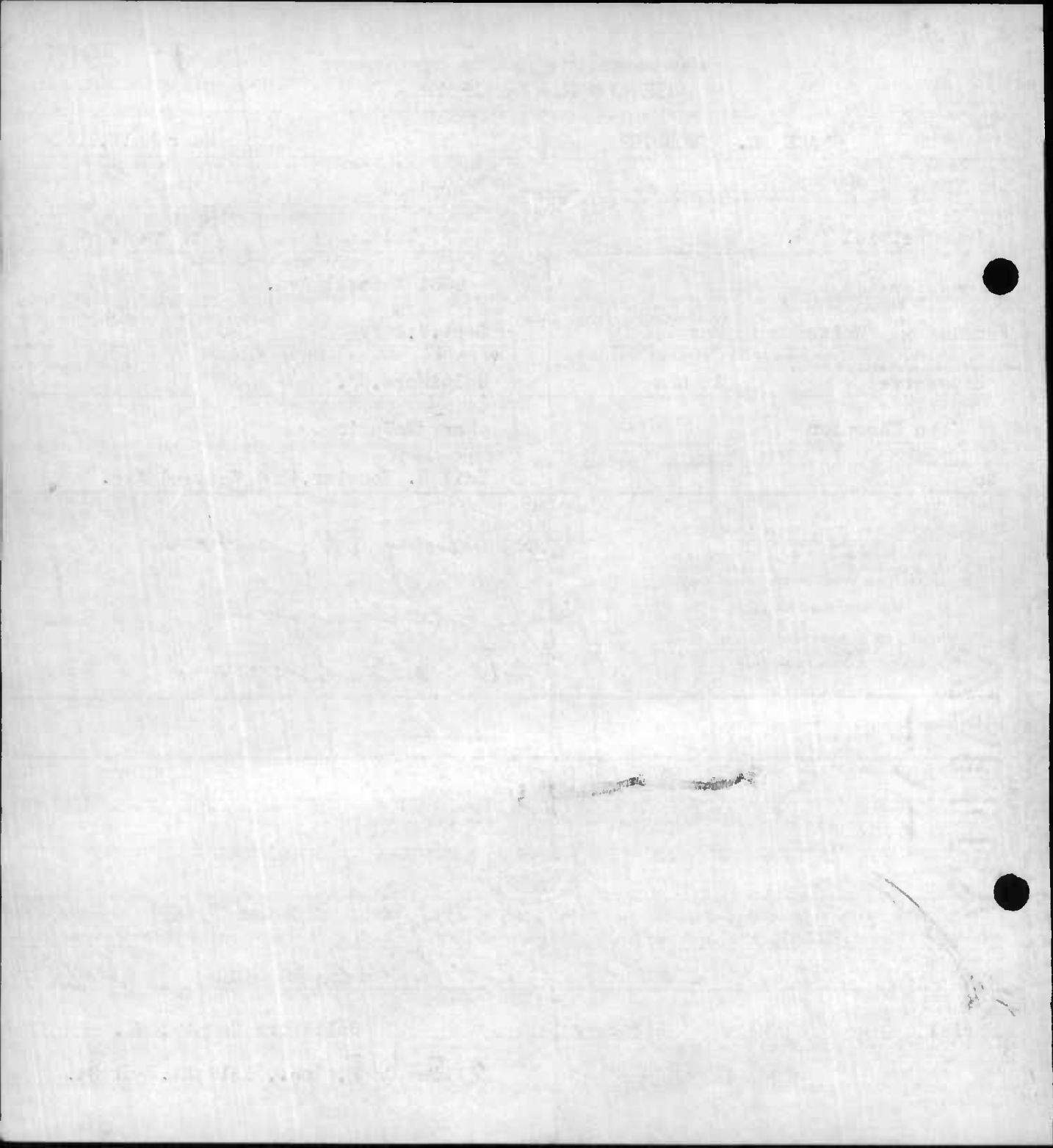
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		GRACE E. MONNIER		2. DATE OF DEATH Ma reh 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY			
5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) 4504 Weitzel Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-02			
6. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 4504 Weitzel Ave.			
7. SEX Female	8. COLOR OR RACE White	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	10. DATE OF BIRTH Sept. 7, 1879		11. AGE (In years last birthday) 70
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		13. KIND OF BUSINESS OR INDUSTRY At home		14. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. CITIZEN OF WHAT COUNTRY?		16. FATHER'S NAME John Thompson		17. MOTHER'S MAIDEN NAME Mary McCa in	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS Emil H. Monnier, 4504 Weitzel Ave.	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 450.0 ?		22. CAUSE OF DEATH (A) Coronary Thrombosis (B) Hypertension (C) Arterio-Sclerosis		23. INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs. 5 yrs.	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
26. DATE OF OPERATION		27. MAJOR FINDINGS OF OPERATION		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		30. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
32. TIME (Month) (Day) (Year) (Hour) OF INJURY		33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		34. HOW DID INJURY OCCUR?	
35. I hereby certify that I attended the deceased from Nov 1949, 1950, to March 17, 1950, that I last saw the deceased alive on March 15, 1950, and that death occurred at 10:30 p. m., from the causes and on the date stated above.					
36. SIGNATURE S. E. H. Henson		37. ADDRESS 1111 W. Overland		38. DATE SIGNED 3/18/50	
39. BURIAL, CREMATION, REMOVAL (Specify) Burial		40. DATE 3/20/50		41. NAME OF CEMETERY OR CREMATORY Ebenezer	
42. LOCATION (City, town, or county) Baltimore County, Md.		43. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St.			

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50 2516

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2516

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Susie B. Jones

2. DATE  
OF  
DEATH

3/16/50 9 a.m.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3204 Hollins Ferry Rd

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

Balto 25-023

D. STREET ADDRESS (If rural, give location)

3204 Hollins Ferry Rd

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 21st 1861

9. AGE (in years)

last birthday

89

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, or if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Un Known

14. MOTHER'S MAIDEN NAME

Un Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John O'Neill 3204 Hollins Ferry Rd.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHabout  
5 yrs.DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive cardio vascular disease

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Old age.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 1944, to March 16, 1950, that I last saw the  
deceased alive on March 15, 1950 and that death occurred at m., from the causes and on the date stated above.

23. SIGNATURE

James S. Mann

M. D.

23B. ADDRESS

516 Cathedral St.

23C. DATE SIGNED

3/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/20/50

24C. NAME OF CEMETERY OR CREMATORY

Landon Park

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

1217 St. Paul St.

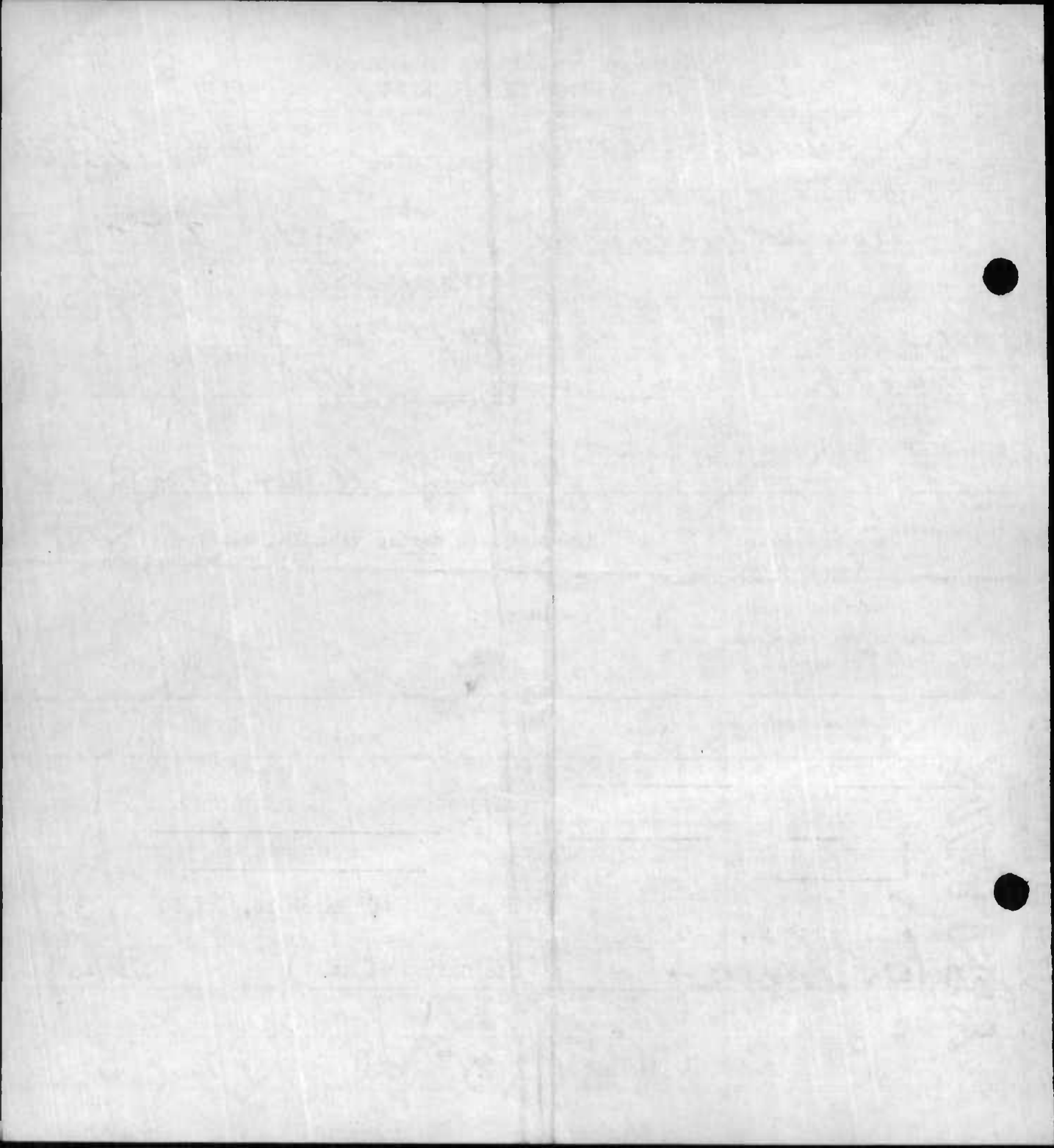
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937

correct age is especially important. Physicians: please write the causes of death clearly and fully.

MEDICAL CERTIFICATION







232  
50 2517

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2517

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>BOB. RISTICK</u>			2. DATE OF DEATH <u>3/17/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>1442 E. Balto St</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 3-01</u>		
D. STREET ADDRESS (If rural, give location) <u>1442 E. Baltimore St</u>			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1868</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>self</u>		
11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>George Ristick</u>			ADDRESS <u>1442 E Balto St</u>		

18. <u>153X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Intestinal Obstruction</u> DUE TO <u>Carcinoma</u> DUE TO <u>Carcinoma sigmoid</u> DUE TO <u>Colon</u> DUE TO _____ DUE TO _____ DUE TO _____	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>1 year</u>
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>		

19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to March, 1950, that I last saw the deceased alive on 3/17, 1950 and that death occurred at 12 A.m., from the causes and on the date stated above.

23A. SIGNATURE <u>Edgar F. Herman</u>	23B. ADDRESS <u>803 Cathedral St</u>	23C. DATE SIGNED <u>3/17/50</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3/20/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Western</u>	24D. LOCATION (City, town, or county) (State) <u>Edmondson Ave Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 20 1950</u>	REGISTRAR'S SIGNATURE <u>Washington Williams</u>	25. FUNERAL DIRECTOR <u>Edmondson Ave</u>	



MINISTRE DU GOUVERNEMENT  
CERTIFICATE OF DEATH

1. NOM ET COGNOM		2. DATES	
3. LIEU DE NAISSANCE		4. LIEU DE DECES	
5. DUREE DE LA MARIAGE		6. DUREE DE LA VIE	
7. DUREE DE LA VIE		8. DUREE DE LA VIE	
9. DUREE DE LA VIE		10. DUREE DE LA VIE	
11. DUREE DE LA VIE		12. DUREE DE LA VIE	
13. DUREE DE LA VIE		14. DUREE DE LA VIE	
15. DUREE DE LA VIE		16. DUREE DE LA VIE	
17. DUREE DE LA VIE		18. DUREE DE LA VIE	
19. DUREE DE LA VIE		20. DUREE DE LA VIE	
21. DUREE DE LA VIE		22. DUREE DE LA VIE	
23. DUREE DE LA VIE		24. DUREE DE LA VIE	
25. DUREE DE LA VIE		26. DUREE DE LA VIE	
27. DUREE DE LA VIE		28. DUREE DE LA VIE	
29. DUREE DE LA VIE		30. DUREE DE LA VIE	
31. DUREE DE LA VIE		32. DUREE DE LA VIE	
33. DUREE DE LA VIE		34. DUREE DE LA VIE	
35. DUREE DE LA VIE		36. DUREE DE LA VIE	
37. DUREE DE LA VIE		38. DUREE DE LA VIE	
39. DUREE DE LA VIE		40. DUREE DE LA VIE	
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59. DUREE DE LA VIE		60. DUREE DE LA VIE	
61. DUREE DE LA VIE		62. DUREE DE LA VIE	
63. DUREE DE LA VIE		64. DUREE DE LA VIE	
65. DUREE DE LA VIE		66. DUREE DE LA VIE	
67. DUREE DE LA VIE		68. DUREE DE LA VIE	
69. DUREE DE LA VIE		70. DUREE DE LA VIE	
71. DUREE DE LA VIE		72. DUREE DE LA VIE	
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85. DUREE DE LA VIE		86. DUREE DE LA VIE	
87. DUREE DE LA VIE		88. DUREE DE LA VIE	
89. DUREE DE LA VIE		90. DUREE DE LA VIE	
91. DUREE DE LA VIE		92. DUREE DE LA VIE	
93. DUREE DE LA VIE		94. DUREE DE LA VIE	
95. DUREE DE LA VIE		96. DUREE DE LA VIE	
97. DUREE DE LA VIE		98. DUREE DE LA VIE	
99. DUREE DE LA VIE		100. DUREE DE LA VIE	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2518  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED <b>BEAMARK BEAN SMITH</b>		2. DATE OF DEATH <b>March 16, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>637 W. Mulberry Street</b>		E. DISTRICT (If rural, give location) <b>4-02</b>	
F. Length of stay in Baltimore <b>7 Yrs. Mos. Days</b>		G. DATE OF BIRTH <b>11-3-1909</b>	
H. SEX <b>Male</b>		I. AGE (In years last birthday) <b>40</b>	
J. COLOR OR RACE <b>Colored</b>		K. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		M. KIND OF BUSINESS OR INDUSTRY <b>Car Washer</b>	
N. FATHER'S NAME <b>Morgan Smith</b>		O. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
P. MOTHER'S MAIDEN NAME <b>Julia Mc Donald</b>		Q. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
R. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <b>no none</b>		S. SOCIAL SECURITY NO. <b>16-100000000</b>	
T. INFORMANT <b>Etta Phine Maynor - 16-100000000</b>		U. ADDRESS <b>16-100000000</b>	

18. <b>451X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <b>Hemopericardium</b> DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Rupture of aorta</b> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <b>Arteriosclerosis</b>			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>H. J. Mc Clafferty</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>3/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>3/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		24F. REGISTRAR'S SIGNATURE <b>W. H. H. H. H.</b>	
24G. FUNERAL DIRECTOR <b>W. H. H. H. H.</b>		24H. ADDRESS <b>98884 Almid J Hill Ave.</b>		24I. ADDRESS <b>98884 Almid J Hill Ave.</b>	



CERTIFICATE OF BIRTH

STATE OF NEW YORK

IN SENATE

JANUARY 1900

CHAPTER 100

SECTION 100

ARTICLE 100

SECTION 100

ARTICLE 100

SECTION 100

ARTICLE 100

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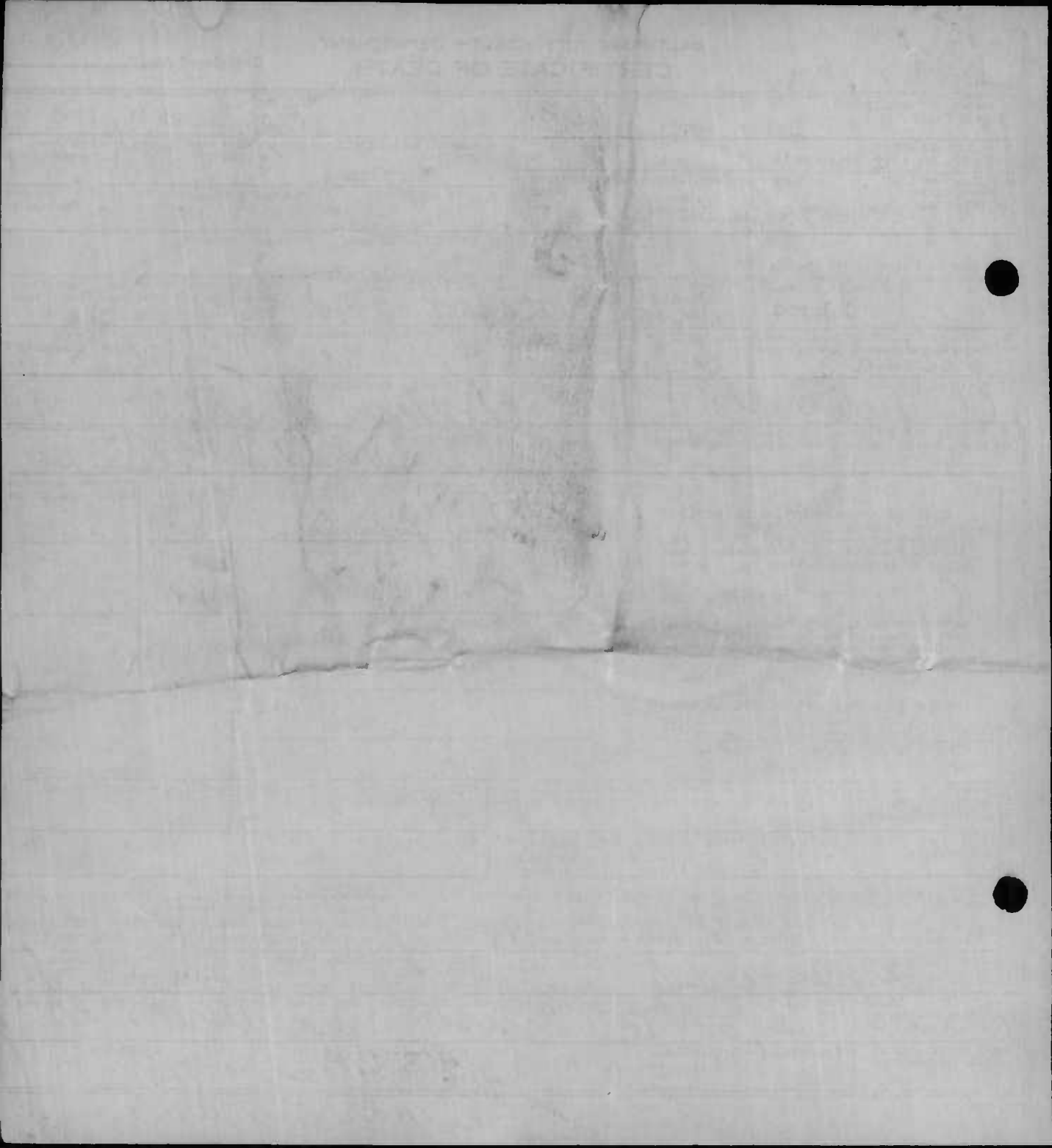
ARTICLE 100

SECTION 100











correct age is especially important. Physicians: please write the causes of death clearly and legibly.

615  
50 2520

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2520

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ALLEN CARPENTER</b>		2. DATE OF DEATH <b>3/15/1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>city</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 17-02</b>	
length of stay in Baltimore <b>20 Yrs. Mos. Days</b>		D. STREET ADDRESS (If rural, give location) <b>1106 - Brewster St.</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 3/1907</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Wood Truck</b>	9. AGE (In years last birthday) <b>42</b>
11. BIRTHPLACE (State or foreign country) <b>Emperor Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mike Carpenter</b>		14. MOTHER'S MAIDEN NAME <b>Sumoia ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Edward Brown</b>		ADDRESS <b>1106 Brewster St.</b>	

18. **490X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pneumonia, bilateral**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **dehydration**

INTERVAL BETWEEN ONSET AND DEATH

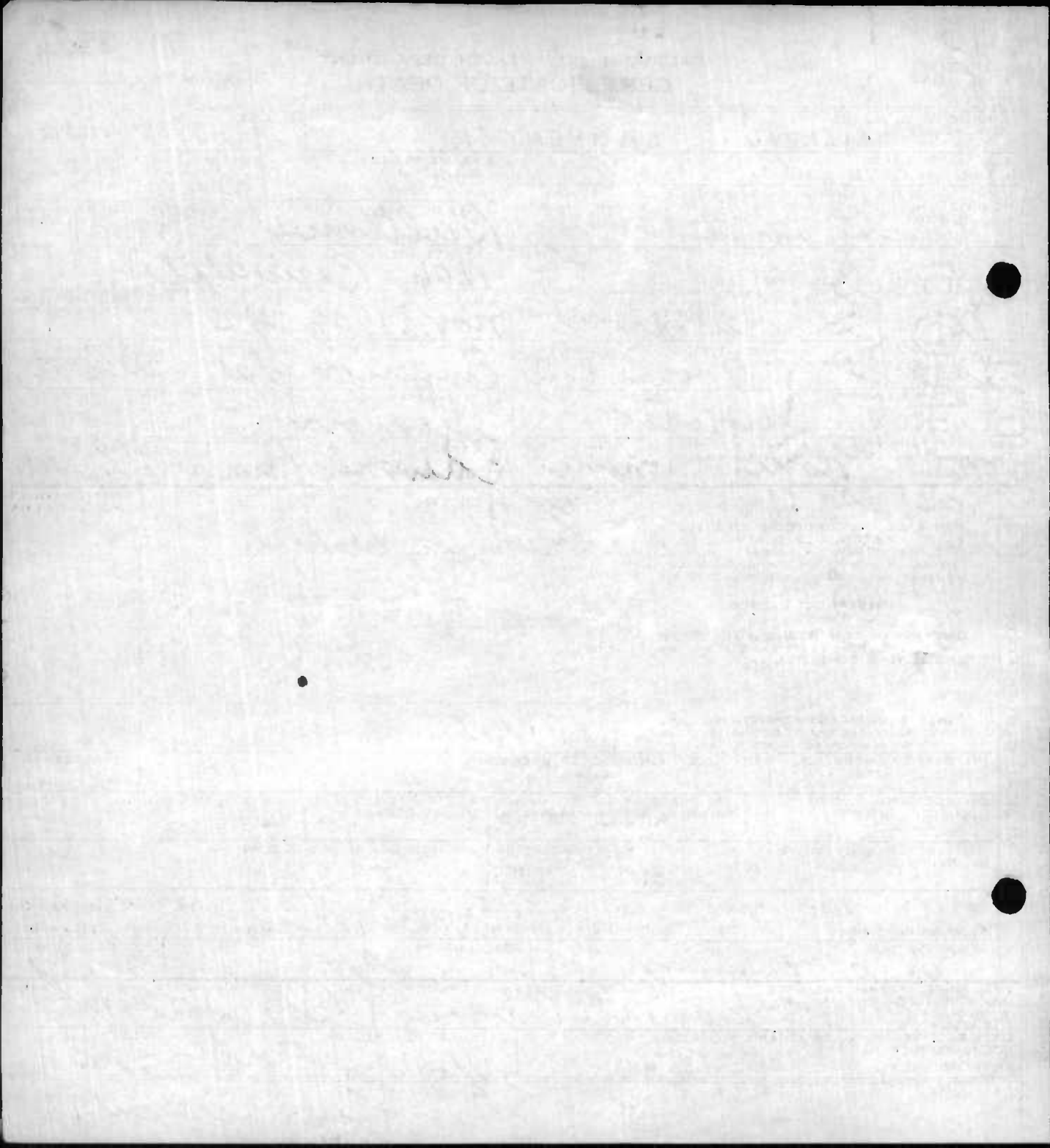
19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **3/15**, 19**50**, to **3/15**, 19**50**, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **10:20 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE **Joseph A. ...** 23B. ADDRESS **...** 23C. DATE SIGNED **3-15-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>3/20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>Cedar Hill Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>	REGISTRAR'S SIGNATURE <b>...</b>	25. FUNERAL DIRECTOR <b>A. Halstead - 918 -</b>	
VS 150		<b>98810</b>	







622  
50 2521BRICKHOUSE  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2521

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter Brickhouse

2. DATE  
OF  
DEATH

3-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Univ. Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. CITY

Md.

City

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balt.

117-01

D. STREET ADDRESS (If rural, give location)

938 - Little Pine St.

5. SEX

C

6. COLOR OR RACE

M

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widower

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

74

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Fertilizer Factory

11. BIRTHPLACE (State or foreign country)

Castelle Va.

12. CITIZEN OF  
WHAT COUNTRY?

W.A.A.

13. FATHER'S NAME

Isaac Brooks

14. MOTHER'S MAIDEN NAME

Mollie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Miss Lizzie M. Cleary - 527 -

ADDRESS

527 -

18. 453.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Pulmonary Embolism

DUE TO

Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Peripheral Occlusive Vasc. Disease

DUE TO

Multiple Old Cerebral Infarctions

(C)

Tumor, sup. Adrenal Medulla

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

20. AUTOPSY?

YES ☒ NO ☐22. I hereby certify that I attended the deceased from 3-15, 1950, to 3-16, 1950, that I last saw the  
deceased alive on 3-16, 1950, and that death occurred at 12<sup>00</sup> A. m., from the causes and on the date stated above.

23A. SIGNATURE

H. G. Smith Jr.

23B. ADDRESS

M. D.

Univ. Hosp.

23C. DATE SIGNED

3-16

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

Wm. H. Williams, M.D.

Al Halstead - 918 -

VS 150

98817

Hend-Hill av. 83B



Request the doctor to  
specify his opinion  
of the underlying cause  
of death



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2522  
Registered No. \_\_\_\_\_

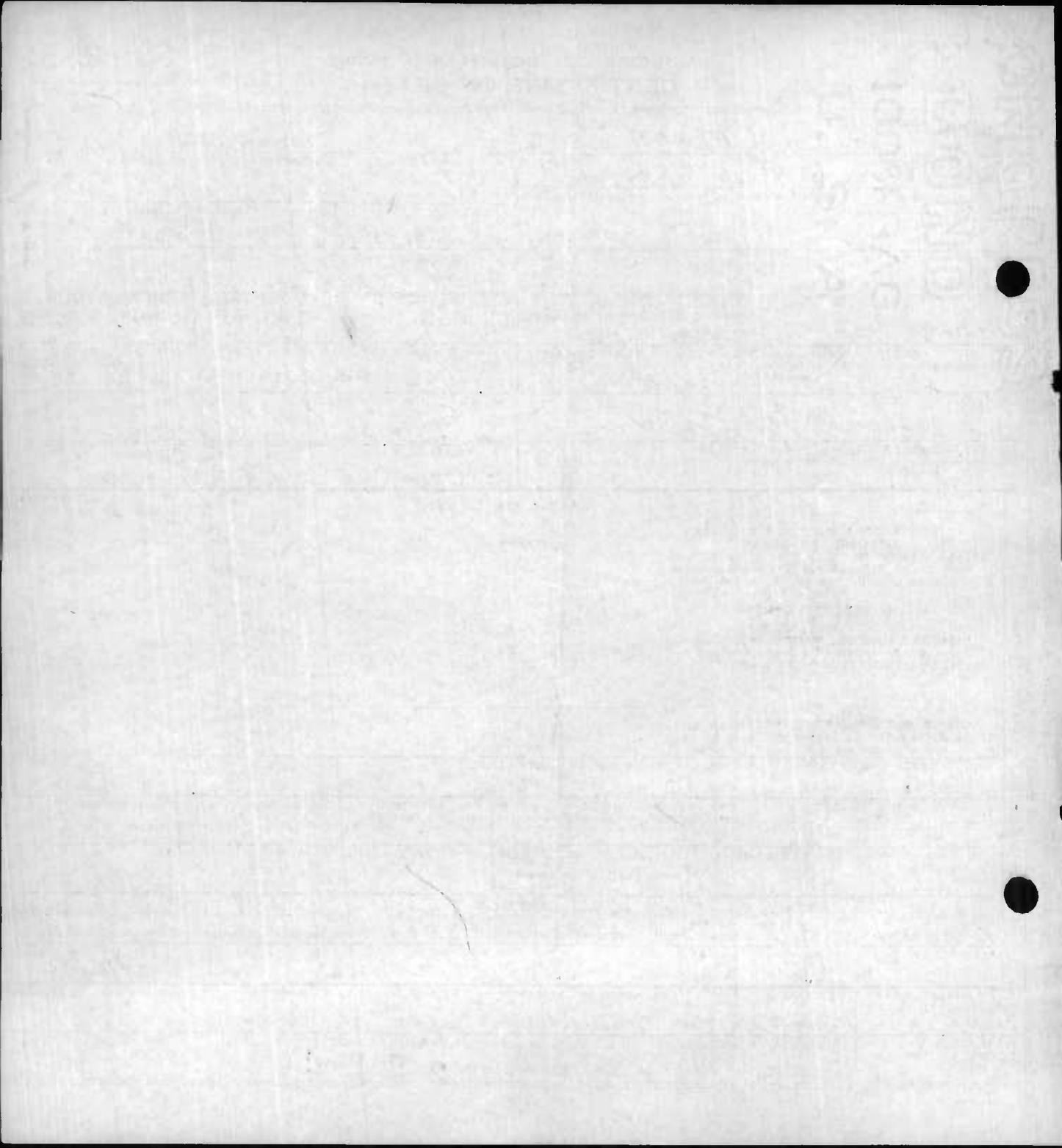
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>DR-F NELSON CRIDER</b>		2. DATE OF DEATH <b>MARCH-18-1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3604 GARRISON BLVD</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <b>BALTIMORE MD 15-10</b>	
D. STREET ADDRESS (if rural, give location) <b>3604 GARRISON BLVD</b>		5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>FEB 19-1897</b> 9. AGE (in years last birthday) <b>53</b> 10. Under 1 Year Months: Days <b>0 24</b> 11. Under 24 Hours Hours: Min. _____		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Samuel N. Crider</b> 14. MOTHER'S MAIDEN NAME <b>Houise C. Raymer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ 16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <b>MRS FLORENTINE CRIDER 3604 GARRISON BLVD</b>	

18. <b>420.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> (A) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b> 19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>March 18, 1950</b> , to <b>March 18, 1950</b> , that I last saw the deceased alive on <b>3/18, 1950</b> , and that death occurred at <b>3:45 p. m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>By Harry Ashman M. D.</b>		23B. ADDRESS <b>3710 Garrison Blvd</b>	23C. DATE SIGNED <b>3/18/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>MARCH-21-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>HORRAINE CEM</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>	REGISTRAR'S SIGNATURE <b>Walter J. Holligan</b>	25. FUNERAL DIRECTOR ADDRESS <b>2337 Phoebe Edmondson Ave</b>	







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2523

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY. L. STEDING

2. DATE  
OF DEATH

MARCH-18-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 606 IV GLOVER ST

A. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore ?

Yrs.  
Mos.  
Days

5. SEX

FEM.

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

APRIL-12-1873 76 yrs.

9. AGE (In years last birthday)

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

GERMANY.

12. CITIZEN OF WHAT COUNTRY?

U S

13. FATHER'S NAME

HENRY TEMPELER

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS CHAS RUEFFEL 3513 BRANDON AVE

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary artery disease  
Myocardial degeneration  
c. pericardial enlargement1 day  
3 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

arteriosclerosis

!

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., to or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan. 1946 to March 18, 1950, that I last saw the deceased alive on March 17, 1950, and that death occurred at 8:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Louis J. Kline

M. D.

23B. ADDRESS

2613 E. Monument St

23C. DATE SIGNED

3/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

MARCH-21-50

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEM.

24D. LOCATION (City, town, or county) (State)

BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR

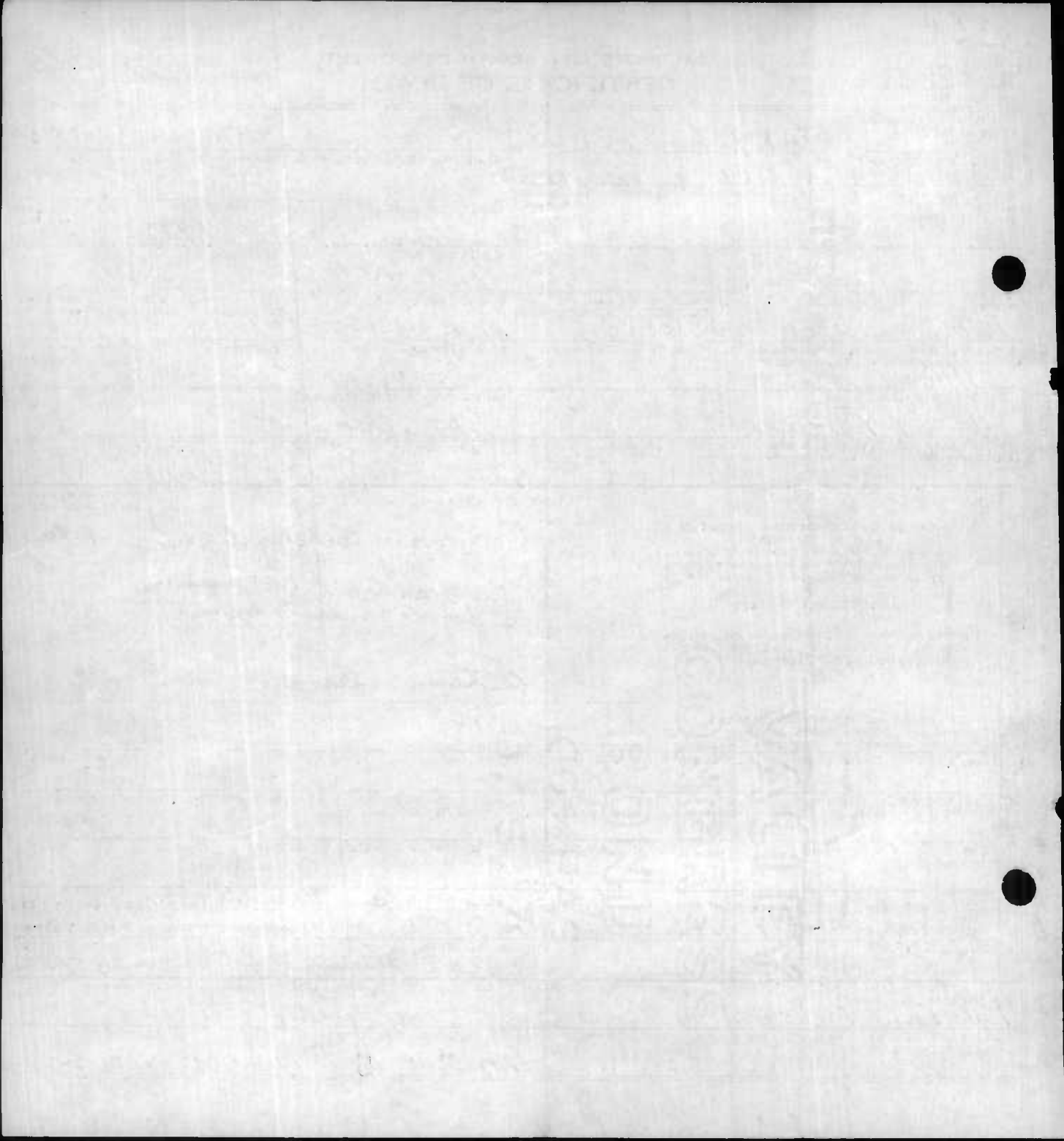
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mr. Geo. B. G. Rohde 2327 EDMONDSON







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be written clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636

50 2524  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2524

1. NAME OF DECEASED (Type or Print) <b>Henry - A. Schroeder</b>		2. DATE OF DEATH <b>MARCH 18 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2661 EDMONDSON AVE.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALT MD 20-02</b>	
Length of stay in Baltimore <b>LIFE TIME</b>		D. STREET ADDRESS (If rural, give location) <b>2661 EDMONDSON AVE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>SEPT 17-1877</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CANDY PACKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DAVE RIBBON</b>	9. AGE (In years last birthday) <b>72</b>
13. FATHER'S NAME <b>WM. F. SCHROEDER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY <b>US</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs MINNIE HILD</b>	
18. <b>443 X</b>		ADDRESS <b>2661 EDMONDSON AVE</b>	

MEDICAL CERTIFICATION

18. <b>443 X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>BRONCHOPNEUMONIA, TERMINAL</b>		<b>72 hrs.</b>
ANTECEDENT CAUSES		(B) <b>Cerebral hemorrhage with right hemiplegia</b>		<b>7 days</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <b>Hypertensive, Cardio-vascular Disease</b>		<b>4 years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>June 1, 1947</b> , to <b>MARCH 18, 1950</b> , that I last saw the deceased alive on <b>MARCH 18, 1950</b> , and that death occurred at <b>11.50 P.m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>Melvin N. Borden</b>		23B. ADDRESS <b>2030 W. Fayette St</b>		23C. DATE SIGNED <b>3/19/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>3-22-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>ST PAULS CEM</b>		24D. LOCATION (City, town, or county) (State) <b>DRUID HILL PARK, BALTO MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Hild</b>		25. FUNERAL DIRECTOR <b>Wm. H. Hild &amp; S. Rohde</b>

496X2

937



• • •



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEWIS  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2525  
Registered No. \_\_\_\_\_

BIRTH NO. 2525

1. NAME OF DECEASED (Type or Print) <b>MELICIA LEWIS</b>		2. DATE OF DEATH <b>3-17-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>112.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV HOSP</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 16-01</b>	
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>626 ARRLINGTON AVE</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>Nov 30, 1894</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>55</b>
13. FATHER'S NAME <b>PATRICK SMITH</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>DAISY BURNING</b>	
17. INFORMANT <b>HOSP. RECORDS</b>		ADDRESS	

MEDICAL CERTIFICATION

18. <b>159X</b> <b>1</b> <b>fully</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatous</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(probable primary site: - G.I. Tract)</b> DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATABLE TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH <b>about 5 yrs</b>
--	--

19A. DATE OF OPERATION <b>3-16-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinomatous</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3-1</b> , 19 <b>50</b> , to <b>3-17</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-17</b> , 19 <b>50</b> , and that death occurred at <b>1:00</b> Am., from the causes and on the date stated above.					
23A. SIGNATURE <b>John W. Stover</b> M. D.		23B. ADDRESS <b>UNIV HOSP</b>		23C. DATE SIGNED <b>3-17-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/21/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Kent Co. Va</b>		24D. LOCATION (City, town, or county) (State) <b>Va</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		REGISTRAR'S SIGNATURE <b>William H. Harrison</b>		25. FUNERAL DIRECTOR <b>Agos H. Nelson</b>		ADDRESS <b>1303 Pinesman St.</b>	

77087

46M



Could you specify  
probable site of  
origin

"

Carcinomatosis - site undetermined.  
Metastatic carcinoma to omentum,  
probably arising from G. I. Tract.  
see Document File 50-2525

4-19-58

Es



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2526  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Jannie Jackson*

2. DATE  
OF  
DEATH

*March 27, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*807 N. Bruce St*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*807 N. Bruce St*

5. SEX

*F*

6. COLOR OR RACE

*COL.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*Feb 1882*

9. AGE (In years - last birthday)

*68*

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*House Wife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*D.C.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*George Hutchins*

14. MOTHER'S MAIDEN NAME

*Louise Hutchins*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Lewis S. Jackson 807 N. Bruce St*

18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Cerebral Hemorrhage*

*2 days*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Malignant Hypertension*

*2 weeks*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

(C)

*Congestive Heart Failure*

*2 wks*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3-12, 1950*, to *3-17, 1950*, that I last saw the deceased alive on *3-17, 1950*, and that death occurred at *2:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*L. W. Anderson*

M. O.

*1612 Edwards Ave*

*3-18-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*3-20-50*

*Balto nat cem.*

*Balto md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

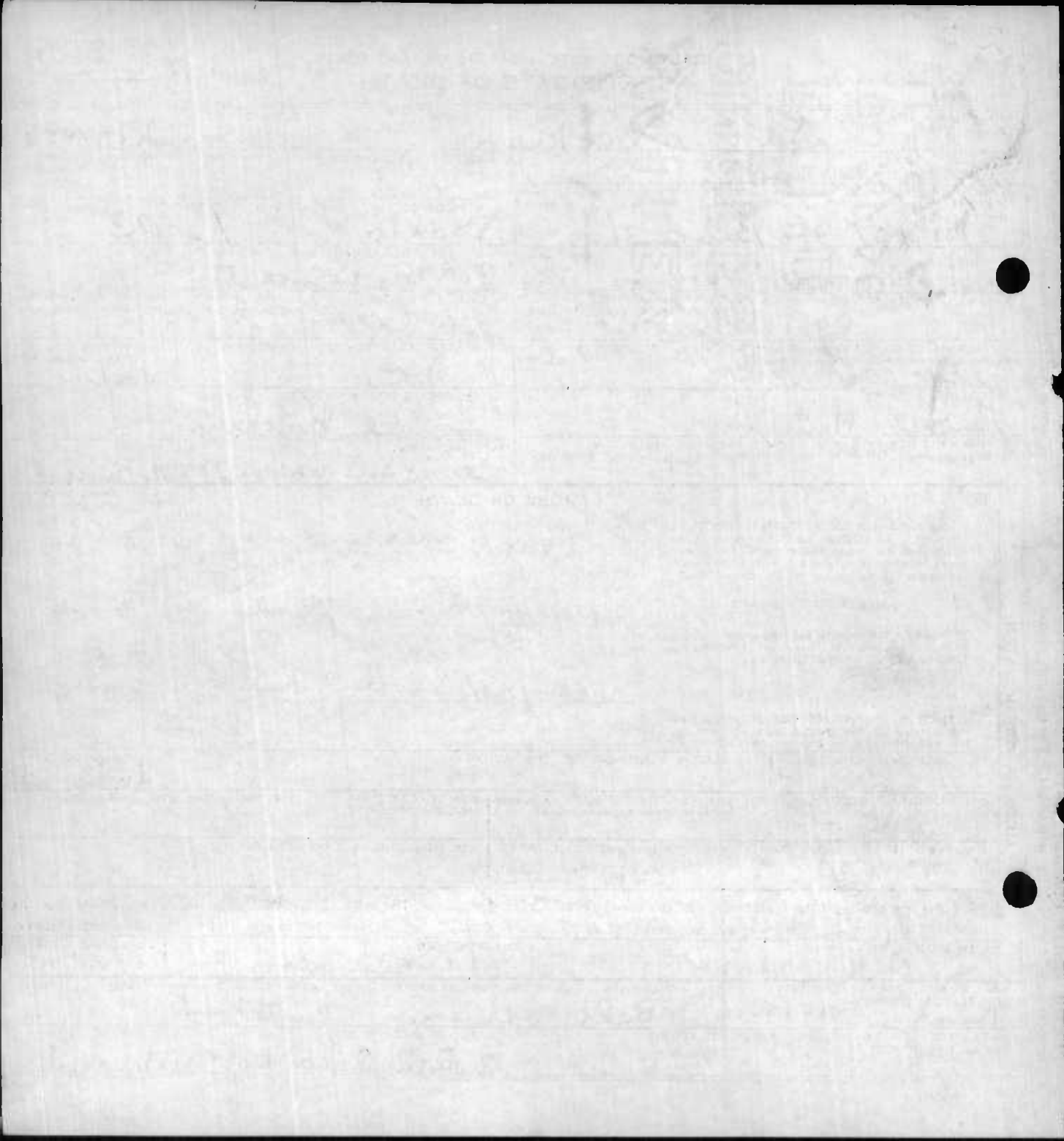
ADDRESS

*MAR 20 1950*

*Wm. H. Williams*

*George B. Nelson 1303 Prestman St*







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANCES SCHAUER

2. DATE  
OF  
DEATH

18 MARCH 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

FRANKLIN SQUARE HOSP.  
FAYETTE + CALHOUN STS.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1816 W. PRATT ST.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Nov. 10, 1901

9. AGE (In years last birthday)

48 49

10. Under 1 Year

Months Days

11. Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

OTTO FILIPPINO

14. MOTHER'S MAIDEN NAME

WILHEMINA FISHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

NO

16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

JOSEPH SCHAUER (HUSBAND) SAME

18. 1520

CAUSE OF DEATH

I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

EMBOLISM  
CEREBRAL THROMBOSIS

INTERVAL BETWEEN ONSET AND DEATH

22 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

AURICULAR FIBRILLATION

NOT KNOWN

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CONGESTIVE HEART FAILURE

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 17 MARCH, 1950 to 18 MARCH, 1950, that I last saw the deceased alive on 18 MARCH, 1950, and that death occurred at 5:40 AM., from the causes and on the date stated above.

23A. SIGNATURE

W. J. Schaub

M. D.

23B. ADDRESS

FRANKLIN SQUARE HOSP.

23C. DATE SIGNED

18 MARCH 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

MAR. 22, 1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

W. J. Schaub

25. FUNERAL DIRECTOR

Geo. L. Schaub

ADDRESS

2101 Frederick Ave.



CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Police Officer

Signature of Fire Department

Signature of Water Department

Signature of Gas Department

Signature of Electric Department

Signature of Telephone Department

Signature of Sewer Department

Signature of Street Department

Signature of Public Works Department



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES HETT

2. DATE  
OF  
DEATH

MARCH 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2214 EAGLE ST.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

20-05

D. STREET ADDRESS (If rural, give location)

2214 EAGLE ST.

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

October 2, 1871

9. AGE (In years last birthday)

78

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FIREMAN

10B. KIND OF BUSINESS OR INDUSTRY

BOILERS (Retired)

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John

HETT

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

EDNA BAUER 2214 EAGLE ST.

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Pulmonary Edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Cardio Vascular Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertension

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 1, 1950, to March 18, 1950, that I last saw the deceased alive on March 18, 1950, and that death occurred at 10:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John H. Hett

M. D.

315 W. Madison Ave.

3/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

MARCH 21, 1950

WESTERN CEMETERY

BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

Wm. H. Hett

GEO. E. SCHUB 2101 FREDERICK AVE.



CERTIFICATE OF DEATH

STATE OF NEW YORK

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Funeral Home	
13. Name of Coroner		14. Name of Medical Examiner		15. Name of Registrar		16. Name of Cemetery	
17. Name of Church		18. Name of Minister		19. Name of Pastor		20. Name of Rector	
21. Name of Priest		22. Name of Rabbi		23. Name of Imam		24. Name of Minister	
25. Name of Pastor		26. Name of Rector		27. Name of Priest		28. Name of Rabbi	
29. Name of Imam		30. Name of Minister		31. Name of Pastor		32. Name of Rector	
33. Name of Priest		34. Name of Rabbi		35. Name of Imam		36. Name of Minister	
37. Name of Pastor		38. Name of Rector		39. Name of Priest		40. Name of Rabbi	
41. Name of Imam		42. Name of Minister		43. Name of Pastor		44. Name of Rector	
45. Name of Priest		46. Name of Rabbi		47. Name of Imam		48. Name of Minister	
49. Name of Pastor		50. Name of Rector		51. Name of Priest		52. Name of Rabbi	
53. Name of Imam		54. Name of Minister		55. Name of Pastor		56. Name of Rector	
57. Name of Priest		58. Name of Rabbi		59. Name of Imam		60. Name of Minister	
61. Name of Pastor		62. Name of Rector		63. Name of Priest		64. Name of Rabbi	
65. Name of Imam		66. Name of Minister		67. Name of Pastor		68. Name of Rector	
69. Name of Priest		70. Name of Rabbi		71. Name of Imam		72. Name of Minister	
73. Name of Pastor		74. Name of Rector		75. Name of Priest		76. Name of Rabbi	
77. Name of Imam		78. Name of Minister		79. Name of Pastor		80. Name of Rector	
81. Name of Priest		82. Name of Rabbi		83. Name of Imam		84. Name of Minister	
85. Name of Pastor		86. Name of Rector		87. Name of Priest		88. Name of Rabbi	
89. Name of Imam		90. Name of Minister		91. Name of Pastor		92. Name of Rector	
93. Name of Priest		94. Name of Rabbi		95. Name of Imam		96. Name of Minister	
97. Name of Pastor		98. Name of Rector		99. Name of Priest		100. Name of Rabbi	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FRANK H. ZIEGLER

2. DATE  
OF  
DEATH

3/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1821 N. MONROE ST

B. FULL NAME OF HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE MA

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

BALTO

15-02

D. STREET ADDRESS (If rural, give location)

1821 N. MONROE ST

Length of stay in Baltimore

63

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OF HAIR

WHT

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PRINTER

10B. KIND OF BUSINESS OR INDUSTRY

SELF.

8. DATE OF BIRTH

DEC-3-1870

9. AGE (In years last birthday)

79

10. Under 1 Year Months: Day

3 15

11. BIRTHPLACE (State or foreign country)

FREDERICK MA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WM. H. ZIEGLER

14. MOTHER'S MAIDEN NAME

MARY ELLEN HALLER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

FRANK IRVIN ZIEGLER 1821 N. MONROE ST

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) DUE TO

Lobar Pneumonia

(B) DUE TO

Chr. Myocarditis

(C)

Chr. Interstitial nephritis

INTERVAL BETWEEN ONSET AND DEATH

3.10.50

1948

1945

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 5, 1950, to Mar 14, 1950, that I last saw the deceased alive on Mar 14, 1950, and that death occurred at 5:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Robert Brown

23B. ADDRESS

1663 W. North Ave

23C. DATE SIGNED

3-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

WOODBURN

24D. LOCATION (City, town, or county)

BALTO Ct.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

Thurston

Geo. H. Leimbach



STATE OF NEW YORK  
CERTIFICATE OF DEATH

LEAH H. LINDEN

1000 1st Avenue

NYC

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue

1000 1st Avenue



534  
50 2530

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2530

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mrs MARTHA O. SCHINDLE</b>		2. DATE OF DEATH <b>3/19/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>HARFORD CONV. HOME</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HARFORD</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>HARFORD CONV. HOME</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 29-05</b>	
D. STREET ADDRESS (If rural, give location) <b>HARVIEW</b>			

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>SEPT 19, 1881</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
13. FATHER'S NAME <b>SOLOMON VESTAL</b>			14. MOTHER'S MAIDEN NAME <b>CAROLINE</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MR. JOHN HOLSEY</b>	
			ADDRESS <b>2304 EDMONDSON AVE</b>			

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>
DUE TO <b>Anterossclerotic C. V. Disease</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 10, 1950</b> , to <b>Mar. 19, 1950</b> , that I last saw the deceased alive on <b>Mar. 19, 1950</b> , and that death occurred at <b>630 P. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William J. J. J.</b>		23B. ADDRESS <b>7101 Harford Rd.</b>		23C. DATE SIGNED <b>3/20/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>3/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Ave</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick Rd</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Frederick Rd</b>		24F. LOCATION (City, town, or county) (State) <b>Frederick Rd</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>		REGISTRAR'S SIGNATURE <b>Thurman J. J.</b>		25. FUNERAL DIRECTOR <b>2427</b>	
				ADDRESS <b>2427</b>	

131 B

correct age is especially important.



1:30 P.M.  
6:30 P.M.

110 Mayford Rd.

Mountain 3869

Granville 1578.











# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 2532

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT

VENEY

2. DATE  
OF  
DEATH

March 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

916 N. Arlington Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie

D. STREET ADDRESS (If rural, give location)

Snowdenton

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 8, 1894

9. AGE (In years last birthday)

55

If Under 1 Year Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Northumberland Co. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Margaret Rice

17. INFORMANT

Hilda Veney 916 N. Arlington Ave.

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

3/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify):  
Burial

24B. DATE

3/20/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

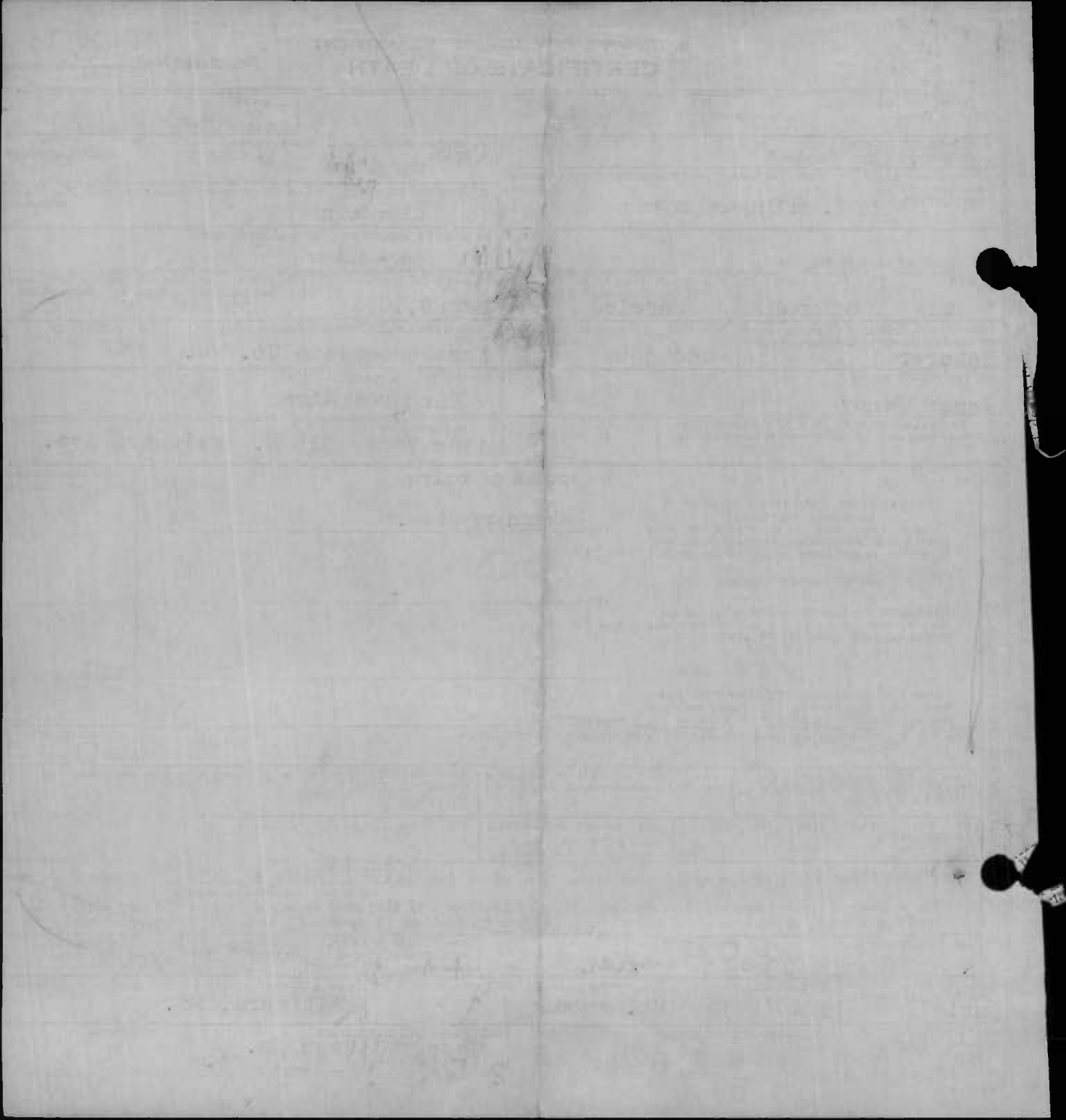
George Gibson Jr.

25. FUNERAL DIRECTOR

1631 Druid Hill Ave.

ADDRESS







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) **Robert Michael Jones**

2. DATE OF DEATH **3-16-1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR **Baltimore City Hospitals**  
INSTITUTION **4940 Eastern Ave.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**2418 Madison Ave.**

Length of stay in Baltimore **life**

Yrs.  
Mos.  
Days

SEX **Male**

6. COLOR OR RACE **Negro**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Single**

8. DATE OF BIRTH  
**March 31, 1949**

9. AGE (In years last birthday) **11** Months **16** Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**none**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
**Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
**Robert Jones**

14. MOTHER'S MAIDEN NAME  
**Thelma Hall**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Records--B.C.H.--4940 Eastern Ave.**

18. **193x**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Brain Tumor**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

*over*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
**3-15-50**

19B. MAJOR FINDINGS OF OPERATION  
**Block at the 3rd. Ventricle**

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-2-**, 19**50** to **3-16-**, 19**50**, that I last saw the deceased alive on **3-16-**, 19**50**, and that death occurred at **2:20P.m.**, from the causes and on the date stated above.

23A. SIGNATURE **[Signature]**

23B. ADDRESS **B.C.H.--4940 Eastern Ave.**

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE **3/20/1950**

24C. NAME OF CEMETERY OR CREMATORY **Arboretum Mem. Ck.**

24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**MAR 20 1950**

**[Signature]**

**Holland Funeral Home**  
**1434 Quind Hill Ave.**



- probable  
Could a histological  
type be determined -  
malignant or benign?

Probably malignant. Letter in document file 50-2533-5/4/50.



PLEASE WRITE legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

420  
50 2534

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2534

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Falise (Irene Elizabeth Falise)</i>		2. DATE OF DEATH <i>3-17-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>15-03</i>			
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1642 Thomas Avenue</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>ABOUT 5/11/03</i>	9. AGE (In years last birthday) <i>ABOUT 46</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Meyers (Myers)</i>		14. MOTHER'S MAIDEN NAME <i>Joanna Nace.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>n one</i>		17. INFORMANT ADDRESS <i>Mr. Charles Falise. 1642 Thomas Ave.</i>	
18. <i>592X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Glomerulonephritis</i>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/16</i> , 1950 to <i>3-17</i> , 1950, that I last saw the deceased alive on <i>3/17</i> , 1950, and that death occurred at <i>6:35 A. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>J. H. [Signature]</i>		23B. ADDRESS <i>1213 Light Street</i>		23C. DATE SIGNED <i>3/17/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Mar. 20, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery.</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 20 1950</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		FURNERAL DIRECTOR ADDRESS <i>4611 Park Heights Ave.</i>	



DEPARTMENT OF HEALTH  
OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1911

REPORT

OF THE

COMMISSIONERS

OF THE

DEPARTMENT OF HEALTH

FOR THE YEAR

1910

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

1911

PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK

ALBANY

1911

1911

1911

1911

1911

1911

1911



correct age is extremely important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2535  
Registered No.

BIRTH NO. 49-24937

1. NAME OF DECEASED  
(Type or Print)

Francis X. Rosenbrock, Jr.

2. DATE  
OF  
DEATH

March 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

West Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2011 Silver Hill Ave.

C. Length of stay in Baltimore

SEX  
M

6. COLOR OR RACE  
W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Nov. 12, 1949

9. AGE (In years  
last birthday)

0

10. Under 1 Year  
Months: Days

4

11. Under 24 Hours  
Hours: Min.

5

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

infant

10B. KIND OF BUSINESS OR  
INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis X. Rosenbrock, Sr.

14. MOTHER'S MAIDEN NAME

June Doyel.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

--

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

--

17. INFORMANT

Sr.

ADDRESS

Mr. Francis X. Rosenbrock, 2911 Silver Hill Ave.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Second and third degree burns

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

2011 Silver Hill Ave.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

March 17, 1950 1 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Crib afire

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED  
March 17, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

3/20/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery, Pikesville, Balto. Co. Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

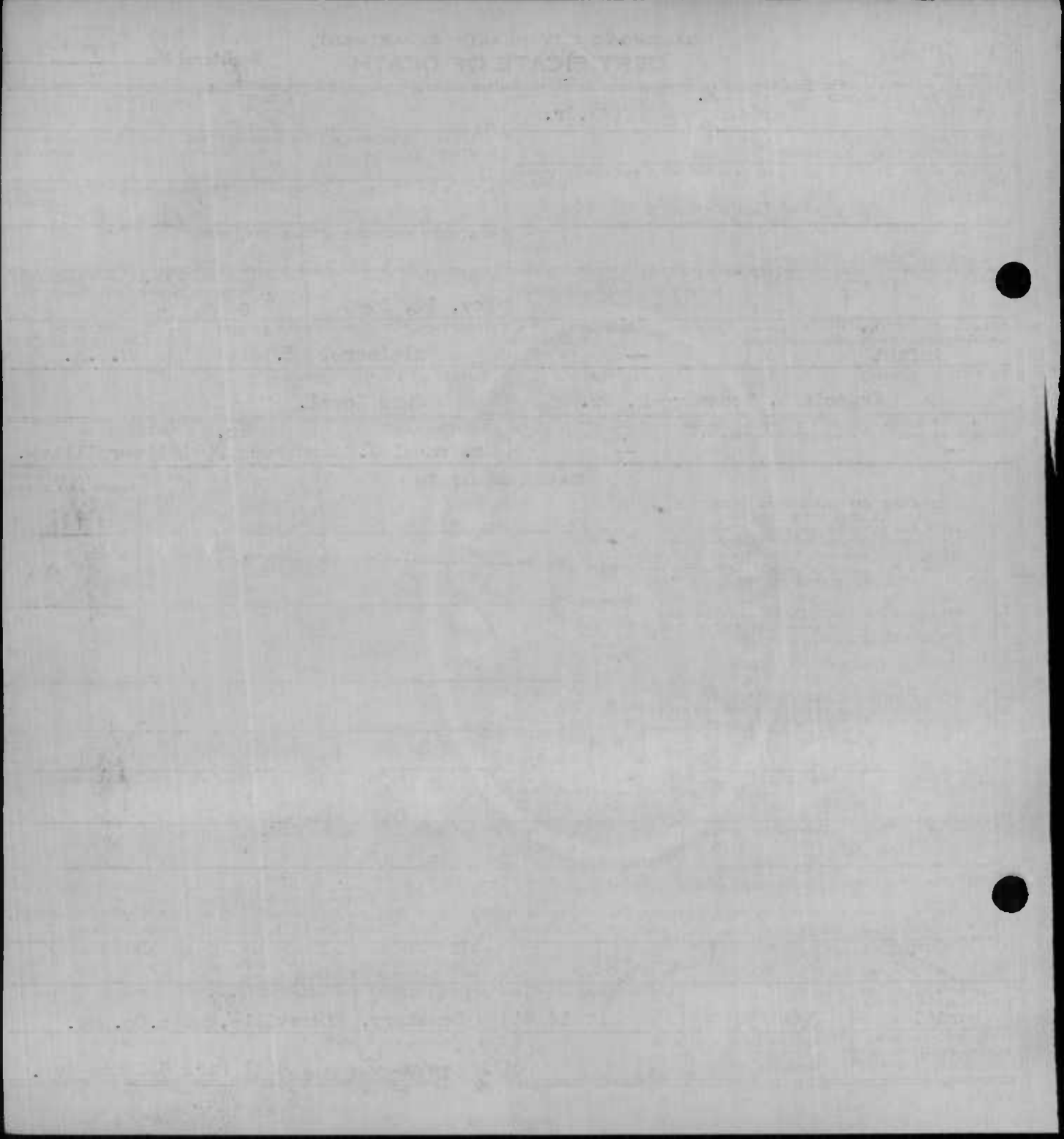
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

4611 Park Heights Ave.







Please write clearly and legibly. The cause of death is especially important. Physicians please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

BENJAMIN BERMAN

2. DATE  
OF  
DEATH

3-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

West Alto Grand

Length of stay in Baltimore 45 Yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

MARRIED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Proprietor

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant Business

13. FATHER'S NAME

Barry

Berman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

Feb 1892

9. AGE (In years last birthday)

58

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA.

14. MOTHER'S MAIDEN NAME

Lena ?

17. INFORMANT

ADDRESS

Mrs. Anna Berman- 2006 Ruxton Avenue

18. 330 X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Subarachnoid Hemorrhage

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Aneurysm, Dissect, Intracranial

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3-17-50

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/18 3:10 PM to 3/19/50, 1950, that I last saw the deceased alive on 3/19, 1950, and that death occurred at 7:17 PM, from the causes and on the date stated above.

23A. SIGNATURE

Joseph M. Shear

M. D.

23B. ADDRESS

W 1220

23C. DATE SIGNED

3/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-20-50

24C. NAME OF CEMETERY OR CREMATORY

Mogan Abraham Congregation Baltimore, Maryland

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter J. Williams

25. FUNERAL DIRECTOR

ADDRESS

Sol Levinson & Bros 1126 W North Ave



STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of religious leader		24. Signature of public official	
25. Signature of justice of the peace		26. Signature of notary public		27. Signature of clerk of court		28. Signature of sheriff	
29. Signature of constable		30. Signature of peace officer		31. Signature of police officer		32. Signature of fire department	
33. Signature of fire marshal		34. Signature of health officer		35. Signature of health department		36. Signature of health commission	
37. Signature of health board		38. Signature of health council		39. Signature of health committee		40. Signature of health association	
41. Signature of health society		42. Signature of health club		43. Signature of health league		44. Signature of health union	
45. Signature of health guild		46. Signature of health association		47. Signature of health society		48. Signature of health club	
49. Signature of health league		50. Signature of health union		51. Signature of health guild		52. Signature of health association	
53. Signature of health society		54. Signature of health club		55. Signature of health league		56. Signature of health union	
57. Signature of health guild		58. Signature of health association		59. Signature of health society		60. Signature of health club	
61. Signature of health league		62. Signature of health union		63. Signature of health guild		64. Signature of health association	
65. Signature of health society		66. Signature of health club		67. Signature of health league		68. Signature of health union	
69. Signature of health guild		70. Signature of health association		71. Signature of health society		72. Signature of health club	
73. Signature of health league		74. Signature of health union		75. Signature of health guild		76. Signature of health association	
77. Signature of health society		78. Signature of health club		79. Signature of health league		80. Signature of health union	
81. Signature of health guild		82. Signature of health association		83. Signature of health society		84. Signature of health club	
85. Signature of health league		86. Signature of health union		87. Signature of health guild		88. Signature of health association	
89. Signature of health society		90. Signature of health club		91. Signature of health league		92. Signature of health union	
93. Signature of health guild		94. Signature of health association		95. Signature of health society		96. Signature of health club	
97. Signature of health league		98. Signature of health union		99. Signature of health guild		100. Signature of health association	



correct age is especially important. Physicians: please write the causes of death clearly and legibly. should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2537

50 2537

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Adolf Meyer</b>			2. DATE OF DEATH <b>March 17, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>4305 Rugby Road</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
Length of stay in Baltimore <b>40</b>			D. STREET ADDRESS (If rural, give location) <b>4305 Rugby Road</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept 13, 1866</b>	9. AGE (in years last birthday) <b>83</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>physician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>professor of psychiatry</b>	11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Rudolf Meyer</b>			14. MOTHER'S MAIDEN NAME <b>Anna Walder</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT ADDRESS <b>Eunice E. Winters, Sec. Towson, Md</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO <b>Arteriosclerosis</b> DUE TO <b>thrombosis of right carotis</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Small bronchopneumonia, left lower lobe</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>		
19A. DATE OF OPERATION <b>1945</b>			19B. MAJOR FINDINGS OF OPERATION <b>Prostatectomy</b>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>July 1, 1948</b> to <b>March 17, 1950</b> that I last saw the deceased alive on <b>March 17, 1950</b> , and that death occurred at <b>11 Am.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Karl Traugott</b>		23B. ADDRESS <b>1633 E. N. Avenue</b>	23C. DATE SIGNED <b>3/16/50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-20-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>	FUNERAL DIRECTOR <b>John C. Mitchell &amp; Sons</b>		ADDRESS <b>1900 Cutaw Place</b>



1950 Fulton D.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

623  
50 2538

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2538  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Marie M. Pracht</b>		2. DATE OF DEATH <b>March 19, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland 4203 Springdale Ave.</b> B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mrs. Lewis Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, 15-08A</b> D. STREET ADDRESS (If rural, give location) <b>3710 Springdale Ave.</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>white</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>		8. DATE OF BIRTH <b>Nov. 3, 1862</b> 9. AGE (In years, last birthday) <b>87</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b> 11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>✓</b>	
13. FATHER'S NAME <b>Charles Praught</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mathes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>491X</b>	
17. INFORMANT <b>Miss Helen Pracht</b>		ADDRESS <b>204 Cedar Croft Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> DUE TO <b>General + cerebral arterio-sclerosis + senility</b> DUE TO <b>1 week</b> DUE TO <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12 Mar</b> , 19 <b>50</b> , to <b>19 Mar</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>19 Mar</b> , 19 <b>50</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Louis E. Wise</b> M. D.		23B. ADDRESS <b>920 St. Paul St.</b>	
23C. DATE SIGNED <b>20 Mar. 50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/21/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Ave. Balto. Md.</b>	
25. FUNERAL DIRECTOR <b>1900 Eutaw Place</b>		ADDRESS <b>1900 Eutaw Place</b>	



# CERTIFICATE OF DEATH

March 14, 1950

John J. Smith

1000 1st St. N.E.

Washington, D.C.

John J. Smith

John J. Smith

John J. Smith

Nov. 2, 1952

John J. Smith

John J. Smith

John J. Smith

John J. Smith

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John J. Smith

John J. Smith



0-160  
50 2539

50 2539

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Daniel Cooper*

2. DATE  
OF  
DEATH

*March 14, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Balto. City*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE *Md* B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 6-05*

D. STREET ADDRESS (If rural, give location)  
*1507 E. Fairmount Ave*

Length of stay in Baltimore

*35 Yrs.*

5. SEX

*male*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Single*

8. DATE OF BIRTH

*2-14-80*

9. AGE (In years last birthday)

*70*

10. Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Laborer*

10B. KIND OF BUSINESS OR INDUSTRY

*In General*

11. BIRTHPLACE (State or foreign country)

*Georgia*

12. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

13. FATHER'S NAME

*Unknown*

14. MOTHER'S MAIDEN NAME

*Unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

*JOHNS HOPKINS HOSPITAL*

ADDRESS

18. *331X I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebral hemorrhage*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arteriosclerosis*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *12/7*, 19*49*, to *3/14*, 19*50*, that I last saw the deceased alive on *3/14*, 19*50*, and that death occurred at *10:35 PM*, from the causes and on the date stated above.

23A. SIGNATURE

*William C. Winterink*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*March 17, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/20/1950*

24C. NAME OF CEMETERY OR CREMATORY

*Mt Calvary Cem.*

24D. LOCATION (City, town, or county)

*Brooklyn A.A.Co.Md*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 20 1950*

REGISTRAR'S SIGNATURE

*William C. Winterink*

25. FUNERAL DIRECTOR

ADDRESS

*Ex 504 Wilson 1000 Brantly Ave*

*98899*

*83a*

PLEASE WRITE PLAINLY, WITH UNBOLDING HAND. Physicians: please write the causes of death clearly and legibly. correct age is especially important.



CERTIFICATE OF DEATH

Signature

John D. [illegible]



M-622

50

2540

## BALTIMORE CITY HEALTH DEPARTMENT

50 2540

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

L. S. Liguazio

MARSIGLIA

2. DATE  
OF  
DEATH

3/17/50

3. PLACE OF DEATH

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Pine Crest Sanatorium

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 21-02

D. STREET ADDRESS (If rural, give location)

1111 Washington Blvd.

Length of stay in Baltimore

35 yrs

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11/26/1883

9. AGE (In years  
last birthday)

66

10. Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Shoe Repairer

10B. KIND OF BUSINESS OR  
INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Marsiglia

14. MOTHER'S M maiden NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Harry Marsiglia 839 Ave Glenwood

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Bronchopneumonia  
TERMINAL

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Myocarditis &  
MYOCARDIAL Degeneneration  
Arteriosclerotic

?

(C)

Generalized Arteriosclerosis

?

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Arteriosclerosis

6 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 4, 1950, to March 17, 1950, that I last saw the deceased alive on MAR 17, 1950, and that death occurred at 1:55 Pm., from the causes and on the date stated above.

23. SIGNATURE

Melvin N. Borden

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

3/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/21/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

John J. Brown

25. FUNERAL DIRECTOR

John J. Brown &amp; Son

ADDRESS

2901 St.

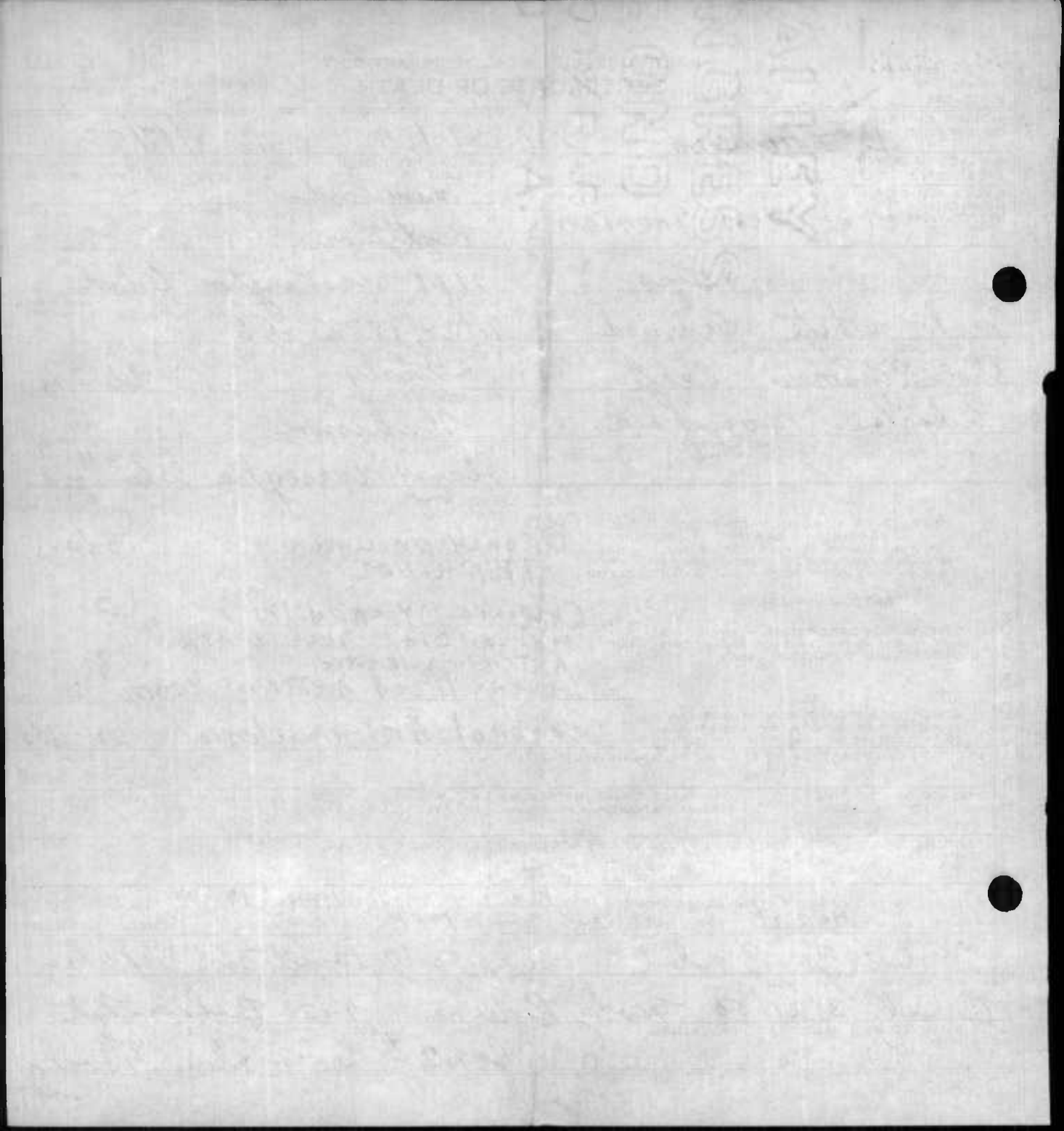
93D St.

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correct age is especially important. Physicians: please write the causes of death clearly and legibly. The







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2541  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) *Arndray Mines*

2. DATE  
OF  
DEATH *March 16, 1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *md.* B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION  
*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 22-02*

D. STREET ADDRESS (If rural, give location)  
*410 S. Paca St.*

Length of stay in Baltimore *15 yrs*

Yrs.  
Mos.  
Days

5. SEX *male*

6. COLOR OR RACE *Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH *3/15/1907*

9. AGE (In years last birthday) *43*  
If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Labourer*

10B. KIND OF BUSINESS OR INDUSTRY  
*Ice Plant (M)*

11. BIRTHPLACE (State or foreign country)  
*Va*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
*Sam Mines*

14. MOTHER'S MAIDEN NAME  
*Und known*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
*212-30-6251*

17. INFORMANT *JOHNS HOPKINS HOSPITAL* ADDRESS \_\_\_\_\_

18. *022X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Esophageal hemorrhage*  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Rupture of syphilitic aortic aneurysm*  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3-16*, 1950, to *3-16*, 1950 that I last saw the deceased alive on *3-16*, 1950, and that death occurred at *10:00 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE  
*William W. Winterlich*

M. D.

23B. ADDRESS  
*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED  
*March 17, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE  
*3/20/1950*

24C. NAME OF CEMETERY OR CREMATORY  
*Mount Auburn Ct*

24D. LOCATION (City, town, or county)  
*Baltimore*

(State)

DATE RECEIVED BY LOCAL REGISTRAR  
*MAR 20 1950*

REGISTRAR'S SIGNATURE  
*William W. Winterlich*

25. FUNERAL DIRECTOR  
*108-26*

ADDRESS  
*2531 N. Montgomery St*



CERTIFICATE OF DEATH

Expenditure of money  
for the purpose of  
the purchase of goods

1870

1870

1870



615  
50 2542BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2542  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) George W. Craven	
2. DATE OF DEATH March 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 4118 Westchester Road	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-03	
D. STREET ADDRESS (If rural, give location) 4118 Westchester Road	
5. SEX Male	6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 15, 1882
9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dyer
11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George H. Craven	14. MOTHER'S MAIDEN NAME Alice Spreckle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) none	16. SOCIAL SECURITY NO. none
17. INFORMANT ADDRESS Mrs. Maude F. Craven 4118 Westchester	
18. 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Arterial degeneration</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 mm.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Arteriosclerosis - nephritic disease</i> DUE TO about 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION none	19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 17, 1949, to March 17, 1950, that I last saw the deceased alive on March 16, 1950, and that death occurred at 8:30 a.m., from the causes and on the date stated above.	
23A. SIGNATURE M. B. Craven and Wood	23B. ADDRESS 2200 Garrison Blvd M. D. March 18-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-21-1950
24C. NAME OF CEMETERY OR CREMATORY Mt. Olive	24D. LOCATION (City, town, or county) (State) Randallstown, Md.
DATE RECEIVED BY LOCAL REGISTRAR MAR 20 1950 VS 150	REGISTRAR'S SIGNATURE G. Howard Strong 3207 W. North Ave., 47406
25. FUNERAL DIRECTOR ADDRESS 131a	

correct age is especially important. Physicians: please use the causes of death clearly and legibly.



Dr. Bergman & Co.  
1200 Linn St.



320  
50 2543

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2543

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Charles A. Witz</i>			2. DATE OF DEATH <i>3-18-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore (17)</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 13-01</i>		
D. STREET ADDRESS (If rural, give location) <i>Emersonian Apartments</i>			E. LENGTH OF STAY IN BALTIMORE <i>years</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>July 21, 1894</i>		9. AGE (In years last birthday) <i>55</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>md. funeral &amp; burial also ORGANIZATION</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, md.</i>
13. FATHER'S NAME <i>M. Henry Witz</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>215304326</i>		
17. INFORMANT <i>Mrs. Mabel R. Witz Emersonian</i>			ADDRESS <i>apd</i>		

18. <i>470.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>acute coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>arteriosclerotic heart disease</i>		<i>years</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 18</i> , 1950, to <i>March 18</i> , 1950, that I last saw the deceased alive on <i>March 18</i> , 1950, and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <i>M. F. Coy 38</i>		23B. ADDRESS <i>Union Memorial Hospital</i>		23C. DATE SIGNED <i>3/18/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/20/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bald Hebrew</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 20 1950</i>		REGISTRAR'S SIGNATURE <i>Union Memorial Hospital</i>		24D. LOCATION (City, town, or county) (State) <i>Belair Rd Baltimore Md</i>	
25. FUNERAL DIRECTOR <i>David Friedheim</i>					

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

2. DATE  
OF  
DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE \_\_\_\_\_ B. COUNTY \_\_\_\_\_

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☐ ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED WAS AT THE TIME OF DEATH

RESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION

AND WAS UNDER THE CARE OF THE AMERICAN HOSPITAL ASSOCIATION

AT THE TIME OF DEATH

AND WAS AT THE TIME OF DEATH

RESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION

AND WAS UNDER THE CARE OF THE AMERICAN HOSPITAL ASSOCIATION

AT THE TIME OF DEATH

AND WAS AT THE TIME OF DEATH

RESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION

AND WAS UNDER THE CARE OF THE AMERICAN HOSPITAL ASSOCIATION

AT THE TIME OF DEATH

AND WAS AT THE TIME OF DEATH



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2545

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**J. W. HARVEY BURGOON**

2. DATE  
OF  
DEATH

**Mar. 18, 1950**

3. PLACE OF DEATH:

A. **Baltimore City, Maryland**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**340 N. Hilton St.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**Md.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Halethorpe**

D. STREET ADDRESS (If rural, give location)

**1217 Leeds Terr.**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**male**

6. COLOR OR RACE

**white**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**widowed**

8. DATE OF BIRTH

**May 7, 1862**

9. AGE (In years last birthday)

**87**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Owner**

10B. KIND OF BUSINESS OR INDUSTRY

**Butter & Egg**

11. BIRTHPLACE (State or foreign country)

**Carroll Co., Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Aaron Burgoon**

14. MOTHER'S MAIDEN NAME

**Louise Hornberger**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**no**

16. SOCIAL SECURITY NO.

**no**

17. INFORMANT

**Mr. John Burgoon**

ADDRESS Av.

**1011 S. Beechfield**

18. **422.1**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

**2 weeks.**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **cardiovascular disease. Enlarged heart, spleen + kidney. C.P.C. of lungs. Enlarged heart**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **3/4**, 19**50**, to **3/18**, 19**50**, that I last saw the deceased alive on **3/18**, 19**50**, and that death occurred at **5:30 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

**12125 Paul St**

**3/19/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**3/21/50**

24C. NAME OF CEMETERY OR CREMATORY

**Loudon Park Cem**

24D. LOCATION (City, town, or county)

**Balto., Md.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**MAR 20 1950**

**Wm. J. Williams**

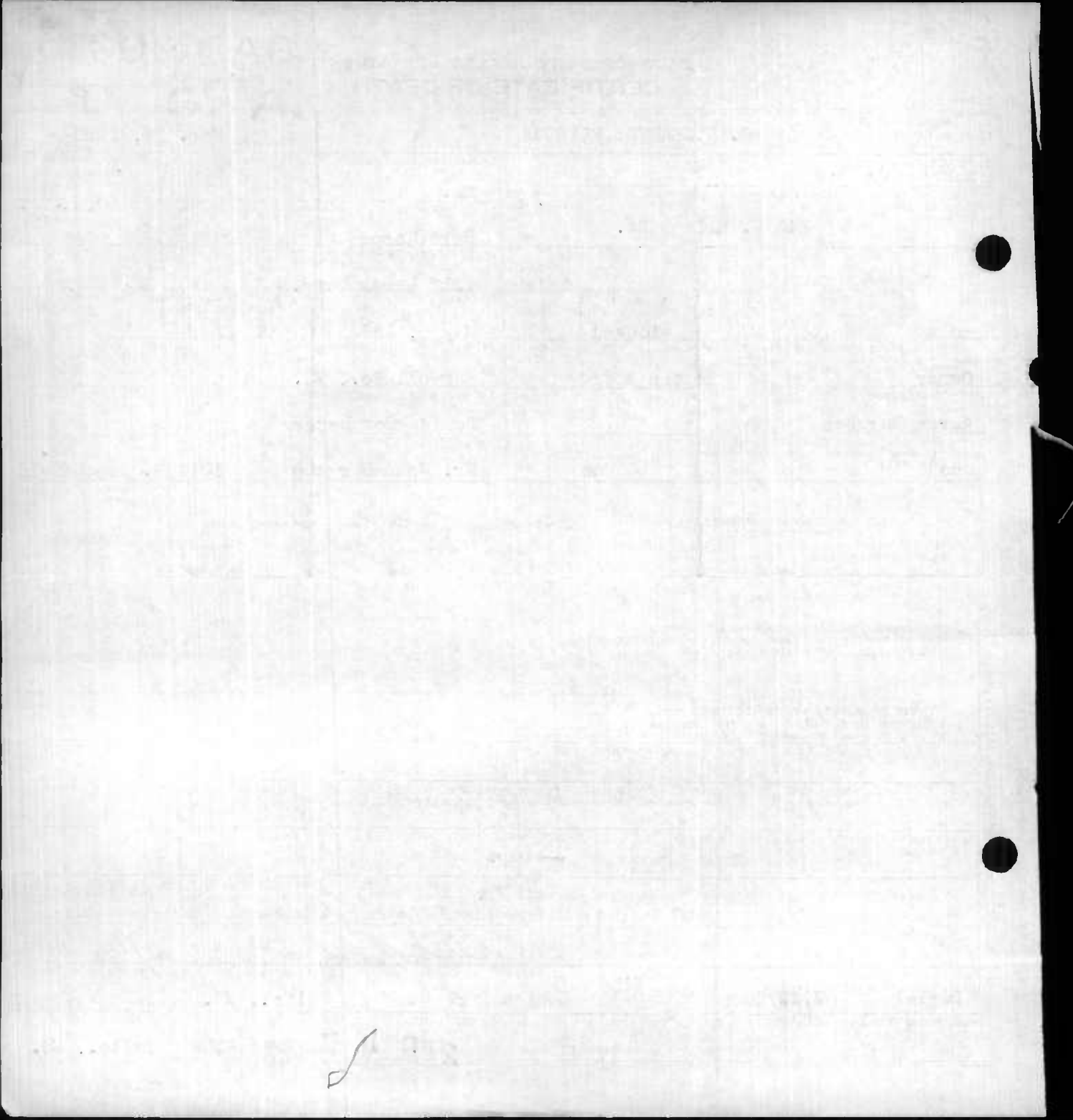
**2215 D. TICKNER & SONS**

**Balto., Md.**

PLEASE WRITE CLEARLY, POST-PAID. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2546  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) *Dolores Snyder*

2. DATE OF DEATH *3-19-50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE *Md* B. COUNTY *Baltimore*

B. FULL NAME OF HOSPITAL OR INSTITUTION  
*St. Agnes Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Satonville 28 5300*

D. STREET ADDRESS (If rural, give location)  
*602 Coleraine Rd.*

5. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX *M*

6. COLOR OR RACE *W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH *2-27-1887*

9. AGE (In years last birthday) *63*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY  
*at home*

11. BIRTHPLACE (State or foreign country)  
*Md.*

12. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

13. FATHER'S NAME  
*Charles Michael*

14. MOTHER'S MAIDEN NAME  
*Emma*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
*no*

16. SOCIAL SECURITY NO.  
*no*

17. INFORMANT

ADDRESS

*Mr. Chester M. Snyder 602 Coleraine Rd.*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *MYOCARDIAL INFARCTION*  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *HYPERTENSIVE ARTERIOSCLEROTIC*  
DUE TO *CARDIO-VASCULAR DISEASE*  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *2*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3/6*, 19*50* to *3/19*, 19*50*, that I last saw the deceased alive on *3/19*, 19*50*, and that death occurred at *7:35* p.m., from the causes and on the date stated above.

23A. SIGNATURE *Charles M. Snyder*

23B. ADDRESS *602 Coleraine Rd.*

23C. DATE SIGNED *3/19/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE *3/22/50*

24C. NAME OF CEMETERY OR CREMATORY *Woodlawn*

24D. LOCATION (City, town, or county) *Woodlawn, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR  
*MAR 20 1950*

REGISTRAR'S SIGNATURE *Walter H. Sullivan*

25. FUNERAL DIRECTOR

ADDRESS

*Wm. J. Tickner & Sons, Balto*

*937 Md.*



12-11-21

67

6)

6

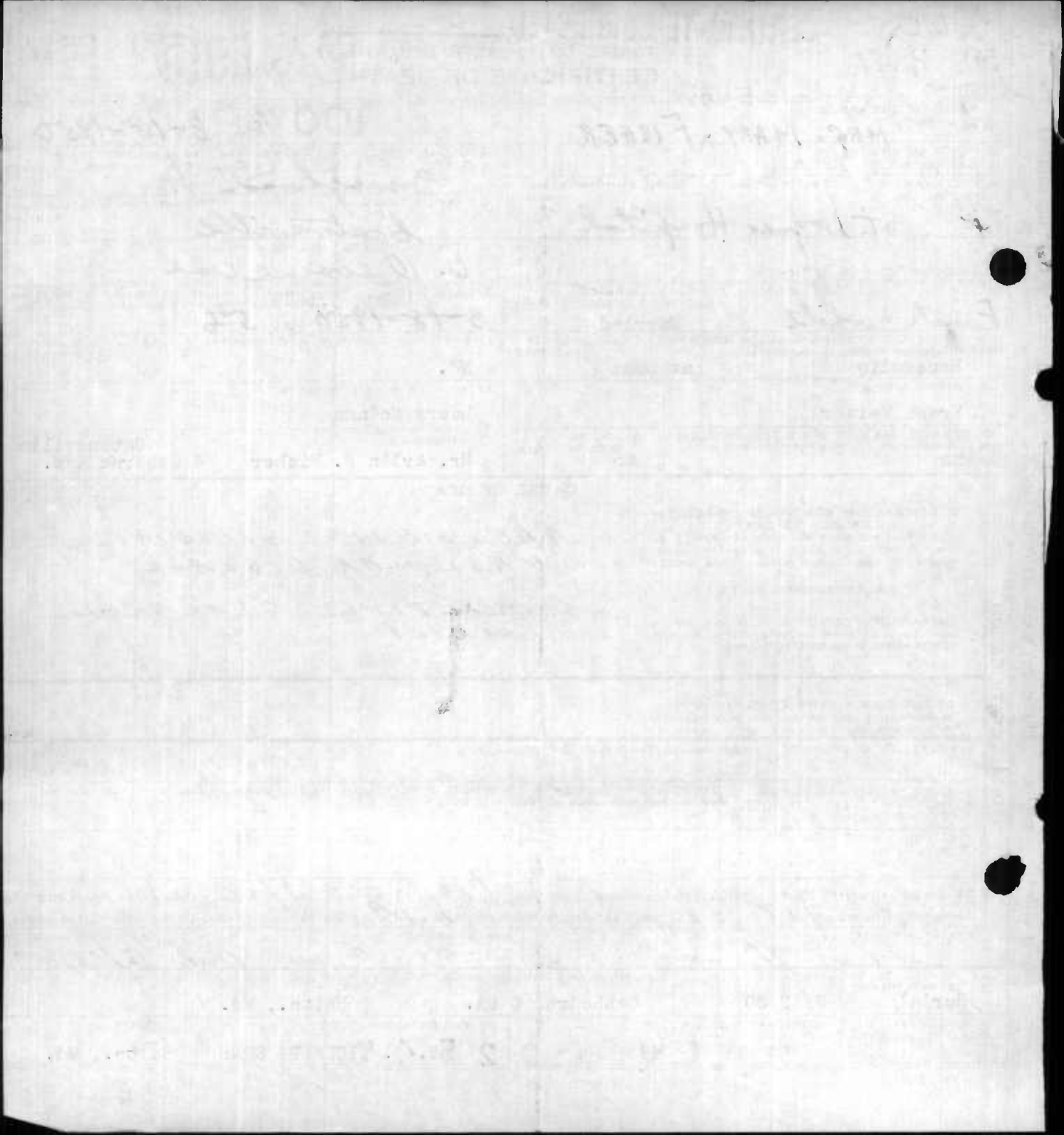
6



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

260		3-23-50		50 2547	
50 2547		BALTIMORE CITY HEALTH DEPARTMENT		50 2547	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3-18-1950	
Mrs. MARY A FISHER					
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN		D. STREET ADDRESS (If rural, give location)	
ST. Agnes Hospital		Baltimore		6. Osborne Ave	
Length of stay in Baltimore		Yrs. Mos. Days			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
Female		white		Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
housewife		at home		March 3, 1889	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Frank Meiser		Laura McCann		61 5-6	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
no		no		Md.	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
Mr. Arlin P. Fisher		6 Osborne Ave.		✓	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) RHEUMATIC CARDITIS			
DUE TO		VASCULAR DISEASE			
ANTECEDENT CAUSES		(B) MULTIPLE CEREBRAL EMBOLI			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
2				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/16, 1950, to 3/18, 1950, that I last saw the deceased alive on 3/18, 1950, and that death occurred at 11:30 p.m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
J. H. Shaw		St. Agnes Hosp.		3/18/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3/22/50		Cathedral C em.	
24D. LOCATION (City, town, or county)		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE	
Balto., Md.		MAR 20 1950		J. H. Shaw	
25. FUNERAL DIRECTOR		ADDRESS			
2 B. & D. PICKNER & SONS		Balto., Md.			







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 3-29-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ernest Herbert Horner

2. DATE  
OF  
DEATH

March 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2321 W. Lafayette Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done, do not list functions, even if retired)

Printer's Office  
Asst. Chief Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Frank Horner

14. MOTHER'S MAIDEN NAME

Kate Sharratts

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

705-05-7986

17. INFORMANT

Mrs. Marie A. Horner

ADDRESS Ave.

2321 W. Lafayette

18. 4/20.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

Instant

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arterio Sclerosis

1 month

15 months

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 18, 1949, to March 15, 1950, that I last saw the deceased alive on March 1, 1950, and that death occurred at 4 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Gains M. Billups

M. D.

23B. ADDRESS

504 Mundsack Road

23C. DATE SIGNED

3/19/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/21/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

W. B. TICKNER & SONS

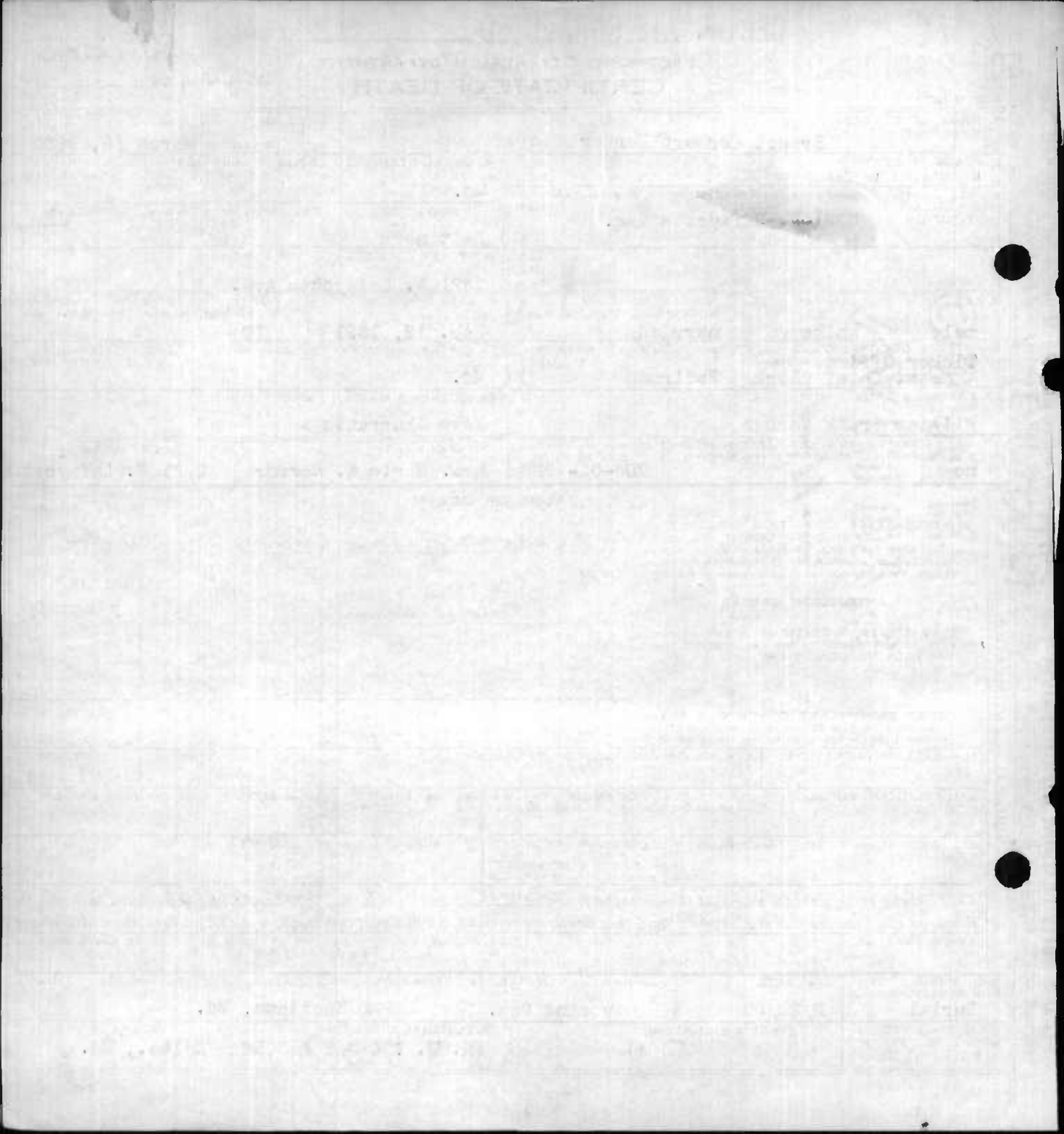
Balto., Md.

VS 150

156 47

94a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

636  
50 2549

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

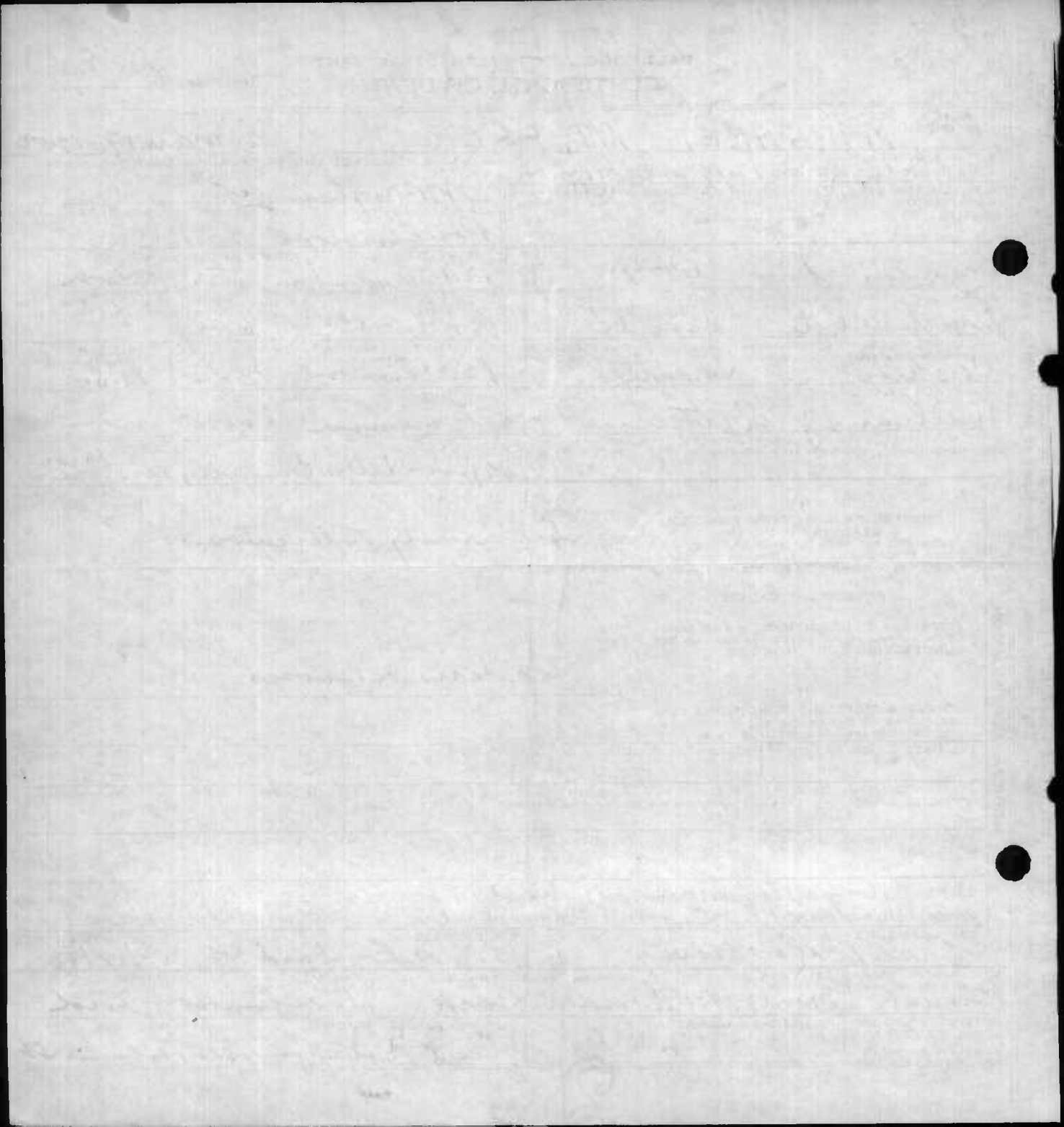
50 2549  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>MARGARET ARTHUR</b>	
2. DATE OF DEATH <b>May. 17 - 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1215 Wash Blvd</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION	
C. Length of stay in Baltimore <b>64 yrs.</b>	
4. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 10 - 1885</b>
9. AGE (In years, last birthday) <b>64</b>	10. Under 1 Year Months: Days
11. Under 24 Hours Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>William J. Arthur</b>	
14. MOTHER'S MAIDEN NAME <b>Emma (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-01-3472</b>	
17. INFORMANT <b>Miss Helen Connolly</b> ADDRESS <b>1215 Wash Blvd</b>	
18. <b>450.0</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>Pulmonary Tuberculosis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>?</b> ANTECEDENT CAUSES (B) <b>Arterio Sclerosis</b> DUE TO (C) <b>?</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.	
19A. DATE OF OPERATION <b>0</b>	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., io or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Sept 17</b> , 19 <b>41</b> , to _____, 19____, that I last saw the deceased alive on <b>May 17</b> , 19 <b>50</b> , and that death occurred at <b>1 P</b> m., from the causes and on the date stated above.	
23A. SIGNATURE <b>Carl Probstling</b> M. O.	
23B. ADDRESS <b>1326 N. Lombard St</b>	
23C. DATE SIGNED <b>3/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>May. 20 - 1950</b>
24C. NAME OF CEMETERY OR CREMATORY <b>Londow Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Ind</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. E. Beyer Jr</b>
25. FUNERAL DIRECTOR ADDRESS <b>1512 Hollins St</b>	

2109V

13B







#530  
50 2550  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2550

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Mildred C. Bailey Smith</i>		2. DATE OF DEATH <i>March 17, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>2633 Borne St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>9-04</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>2633 Borne St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 27, 1911</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>38</i>
13. FATHER'S NAME <i>Henry Carter</i>		1. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. <i>-</i>		14. MOTHER'S MAIDEN NAME <i>Mattie ?</i>	
17. INFORMANT <i>James Smith</i>		ADDRESS <i>2633 Borne St</i>	

18. <i>447 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>hypertensive cardio-renal</i> DUE TO <i>DISCIC (VIRGINIA)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>VNK</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

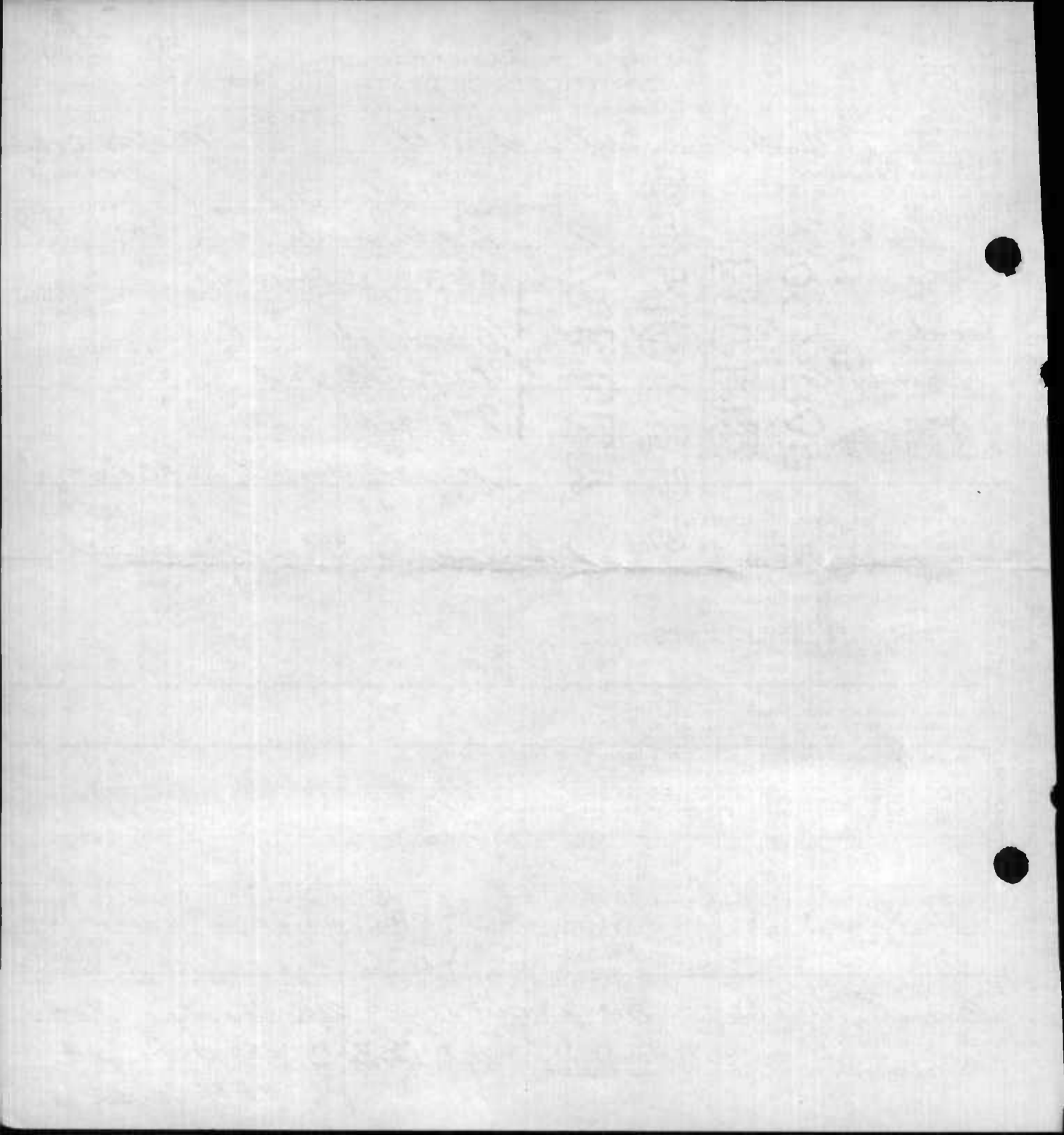
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3.14</i> , 19 <i>50</i> , to <i>3.17</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/16</i> , 19 <i>50</i> , and that death occurred at <i>9:30 A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <i>1500 EAST BROADWAY, BALTIMORE 3, MD.</i>		23C. DATE SIGNED <i>3-20-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>March 20/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>A. A. County md</i>		24E. FUNERAL DIRECTOR <i>Mrs. G. H. &amp; E. J. Edgar &amp; Daughter</i>		ADDRESS <i>1297 N. Caroline ST</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 20 1950</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		VS 150	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

13/a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is especially important. Physicians: please write the causes of death clearly and legibly.

500  
50 2551

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2551  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Wilhelmina B Torrey

2. DATE  
OF  
DEATH

3-17-58

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2005 ANNAPOLIS AVE

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

2005 Annapolis Ave  
Balto Md. 5-0-58

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 16-1882 76 68

9. AGE (In years,  
last birthday)

If Under 1 Year

If Under 24 Hours

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Bety

14. MOTHER'S MAIDEN NAME

Louise Betty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charles E. Torrey 2005 Annapolis

18. 216 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Ovarian cyst  
with intestinal obstructions

3 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

none

II

(C)

none

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 3/13 1950, to 3/17 1950, that I last saw the deceased alive on 3/17 1950, and that death occurred at 3:10 m., from the causes and on the date stated above.

23A. SIGNATURE

William Bety

23B. ADDRESS

2030 Wilkens Ave 3/20/50

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3-20-50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county) (State)

Ritchie Hgwy

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Bety

25. FUNERAL DIRECTOR

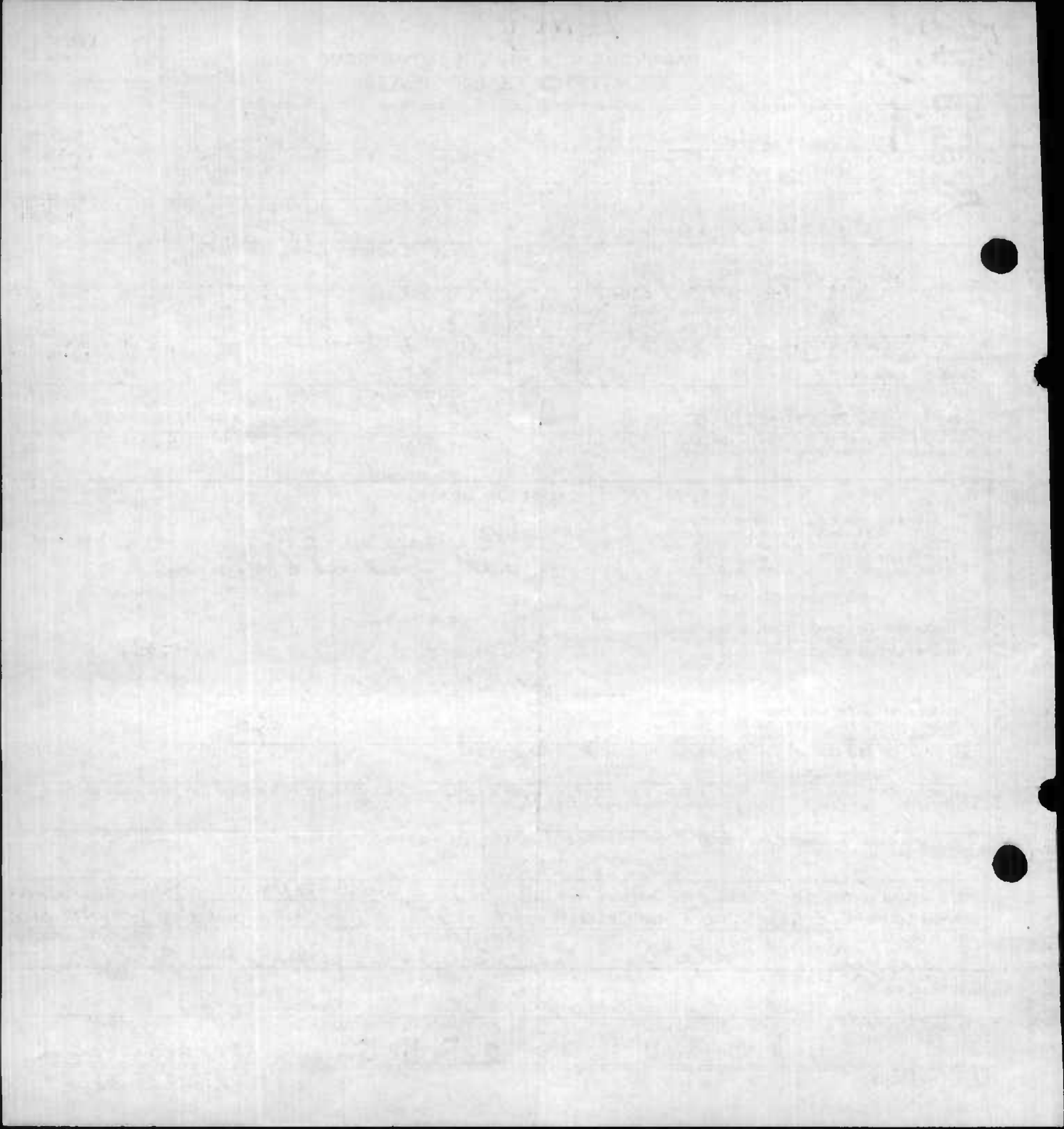
ADDRESS

Edmund Foulson 2357 Wash Blvd

MAR 20 1950

Balto Md  
56a







Heinst

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2552  
Registered No.1. NAME OF DECEASED  
(Type or Print)

Mary Heinst

2. DATE  
OF  
DEATH

March 18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTIONLittle Sisters of the Poor  
Home for the Aged

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS

18. 472.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) .....

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from March 2, 1950, to March 18, 1950 that I last saw the  
deceased alive on March 18, 1950, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

E. Gill Hall M.D.

23B. ADDRESS

1631 E North Ave

23C. DATE SIGNED

3/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



19 227











**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2554  
Registered No. \_\_\_\_\_

BIRTH NO. 0-520 2554 10-05974

1. NAME OF DECEASED (Type or Print) <b>Sean R. Owens</b>		2. DATE OF DEATH <b>March 20, 1950</b>	
3. PLACE OF DEATH: a. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>2401 Ailsa Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
e. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		d. STREET ADDRESS (If rural, give location) <b>2401 Ailsa Ave.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>March 13, 1950</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John P. Owens</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Rogers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>		17. INFORMANT ADDRESS <b>John P. Owens, 2401 Ailsa Ave.</b>	

18. <b>7562</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>Acute intestinal obstruction probably due to volvulus of colon</b> DUE TO _____  (B) _____ DUE TO _____  (C) _____
--	---

19A. DATE OF OPERATION <b>3</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Earl R. Ryan M.D. 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **March 20, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE **3/20/1950** 24C. NAME OF CEMETERY OR CREMATORY New Bethesda 24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR **MAR 20 1950** REGISTRAR'S SIGNATURE Earl R. Ryan 25. FUNERAL DIRECTOR John E. Gosan ADDRESS 3020 Baltimore

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral home		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of burial		19. Signature of burial		20. Signature of burial	
21. Signature of burial		22. Signature of burial		23. Signature of burial		24. Signature of burial	
25. Signature of burial		26. Signature of burial		27. Signature of burial		28. Signature of burial	
29. Signature of burial		30. Signature of burial		31. Signature of burial		32. Signature of burial	
33. Signature of burial		34. Signature of burial		35. Signature of burial		36. Signature of burial	
37. Signature of burial		38. Signature of burial		39. Signature of burial		40. Signature of burial	
41. Signature of burial		42. Signature of burial		43. Signature of burial		44. Signature of burial	
45. Signature of burial		46. Signature of burial		47. Signature of burial		48. Signature of burial	
49. Signature of burial		50. Signature of burial		51. Signature of burial		52. Signature of burial	
53. Signature of burial		54. Signature of burial		55. Signature of burial		56. Signature of burial	
57. Signature of burial		58. Signature of burial		59. Signature of burial		60. Signature of burial	
61. Signature of burial		62. Signature of burial		63. Signature of burial		64. Signature of burial	
65. Signature of burial		66. Signature of burial		67. Signature of burial		68. Signature of burial	
69. Signature of burial		70. Signature of burial		71. Signature of burial		72. Signature of burial	
73. Signature of burial		74. Signature of burial		75. Signature of burial		76. Signature of burial	
77. Signature of burial		78. Signature of burial		79. Signature of burial		80. Signature of burial	
81. Signature of burial		82. Signature of burial		83. Signature of burial		84. Signature of burial	
85. Signature of burial		86. Signature of burial		87. Signature of burial		88. Signature of burial	
89. Signature of burial		90. Signature of burial		91. Signature of burial		92. Signature of burial	
93. Signature of burial		94. Signature of burial		95. Signature of burial		96. Signature of burial	
97. Signature of burial		98. Signature of burial		99. Signature of burial		100. Signature of burial	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2555  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Rosie E. Sclothe

2. DATE  
OF  
DEATH

March 17th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

525 Rosehill Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

525 Rosehill Terrace

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept 29th 1863

9. AGE (In years  
last birthday)

86

10 Under 1 Year  
Months Days

11 Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Sears

14. MOTHER'S MAIDEN NAME

Ella Armiger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS Terra

Mrs. J. Kirby Weber 525 Rosehill ce

18. 442x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertension, Cardio-vascular renal  
disease 5 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Tumor of rt. side of neck, type + cause undetermined 4 mo.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from Dec. 31, 1949, to Mar. 17, 1950, that I last saw the deceased alive on Mar. 16, 1950, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Lloyd E. Saylor

M. D.

23B. ADDRESS

3902 Greenmount Ave.

23C. DATE SIGNED

Mar. 8, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/20/50

24C. NAME OF CEMETERY OR CREMATORY

Morland Memorial Park

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

John B. Moran

3000 E. Balto. St.

VS 150

131a



STATE OF OHIO

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONER

OF THE

LANDS

AND

MINES

OF THE

STATE

OF OHIO

FOR THE

YEAR

1899

AND

FOR THE

YEAR

1900

AND

FOR THE

YEAR

1901

AND

FOR THE

YEAR



PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

H-452  
50 2556

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2556  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>ZOFIA (Zophia) Helaska</i>			2. DATE OF DEATH <i>3/19/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>534 N. Curley St</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore MD 7-01</i>		
C. Length of stay in Baltimore <i>55</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>534 N. Curley St</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug. 15, 1878</i>		9. AGE (in years last birthday) <i>71</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Sobus</i>			14. MOTHER'S MAIDEN NAME <i>Rose Skrawczyk</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Thomas Helinski, 534 N. Curley St.</i>		

18. <i>4221</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic disease</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>P. Helinski</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	23C. DATE SIGNED <i>3/19/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/23/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 20 1950</i>		REGISTRAR'S SIGNATURE <i>195000</i>	25. FUNERAL DIRECTOR <i>1808 Eastern Avenue</i>



STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS		TREATMENT		POST-MORTEM	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	



656  
50 2557  
50 2557

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2557  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Samuel Shaffer Creamer</b>			2. DATE OF DEATH <b>3-19-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Ma</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>27-03</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>4804 Pilgrim Rd. -14</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>Sept. 11, 1861</b>	9. AGE (In years, last birthday) <b>88</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Retired Harness Maker</b>			11. BIRTHPLACE (State or foreign country) <b>Ma.</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Alexander Creamer</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave.</b>			ADDRESS		

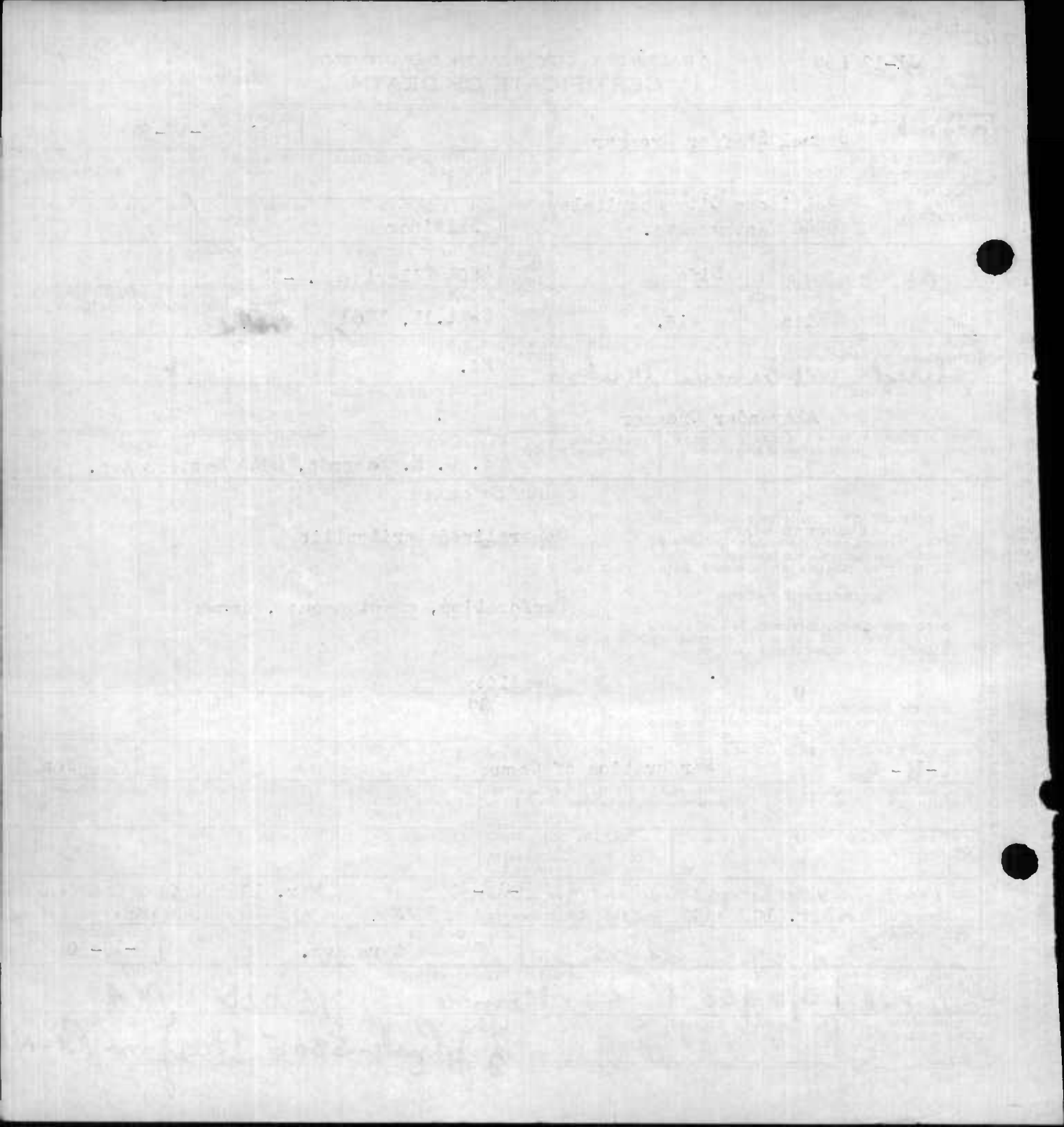
18. <b>578X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Peritonitis</b> (A) _____ DUE TO  ANTECEDENT CAUSES <b>Perforation, spontaneous, cecum</b> (B) _____ DUE TO  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>Senility</b> (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
--	----------------	----------------------------------

19A. DATE OF OPERATION <b>3-19-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Perforation of Cecum</b>		20. AUTOPSY? YES <input type="checkbox"/> No <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3-18-50</b> , 19__, to <b>Mar. 19</b> , 1950, that I last saw the deceased alive on <b>Mar. 19</b> , 1950, and that death occurred at <b>3 AM.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>3-19-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>L. J. Luck-5305 Harford Rd-14</b>		ADDRESS	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.







152  
50 2558BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2558  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary V. Robinson

2. DATE  
OF  
DEATH

Mar 16-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4907 Catalpha Rd.

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution; residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4907 Catalpha Road

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb. 11-1889

9. AGE (In years  
last birthday)

61

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Christopher Rosendale

14. MOTHER'S MAIDEN NAME

Mary Rosener

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother Schaff - 4907 Catalpha

18. 170 X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Generalized Carcinoma

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Cancer of Right breast  
removed Jan 2, 1948.

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

14 mos.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 23, 1949, to March 16, 1950, that I last saw the  
deceased alive on March 15, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

23A. SIGNATURE

James E. White

23B. ADDRESS

5214 Harford Rd.

23C. DATE SIGNED

17 Mar 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

VS 150

50



Dr. White



656

50 2559

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2559  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John J. Schirmer

2. DATE  
OF  
DEATH

Mar 17-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Little Sisters of Poor

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1003 N. Calvert Street

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Aug. 4-1867

9. AGE (in years  
last birthday)

82

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Salesman

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

August Schirmer

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Raymond Schirmer - 3321 Caton

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Edema Lungs

1 day

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Myocarditis

5 y6

DUE TO

(C)

Arterio Sclerosis

W y6

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in- or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from March 1-, 1950, to March 17, 1950, that I last saw the  
deceased alive on March 17, 1950, and that death occurred at 3:45 P m., from the causes and on the date stated above.

23A. SIGNATURE

E. Gill Hall MD

M. D.

23B. ADDRESS

1631 E North Ave

23C. DATE SIGNED

March 18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

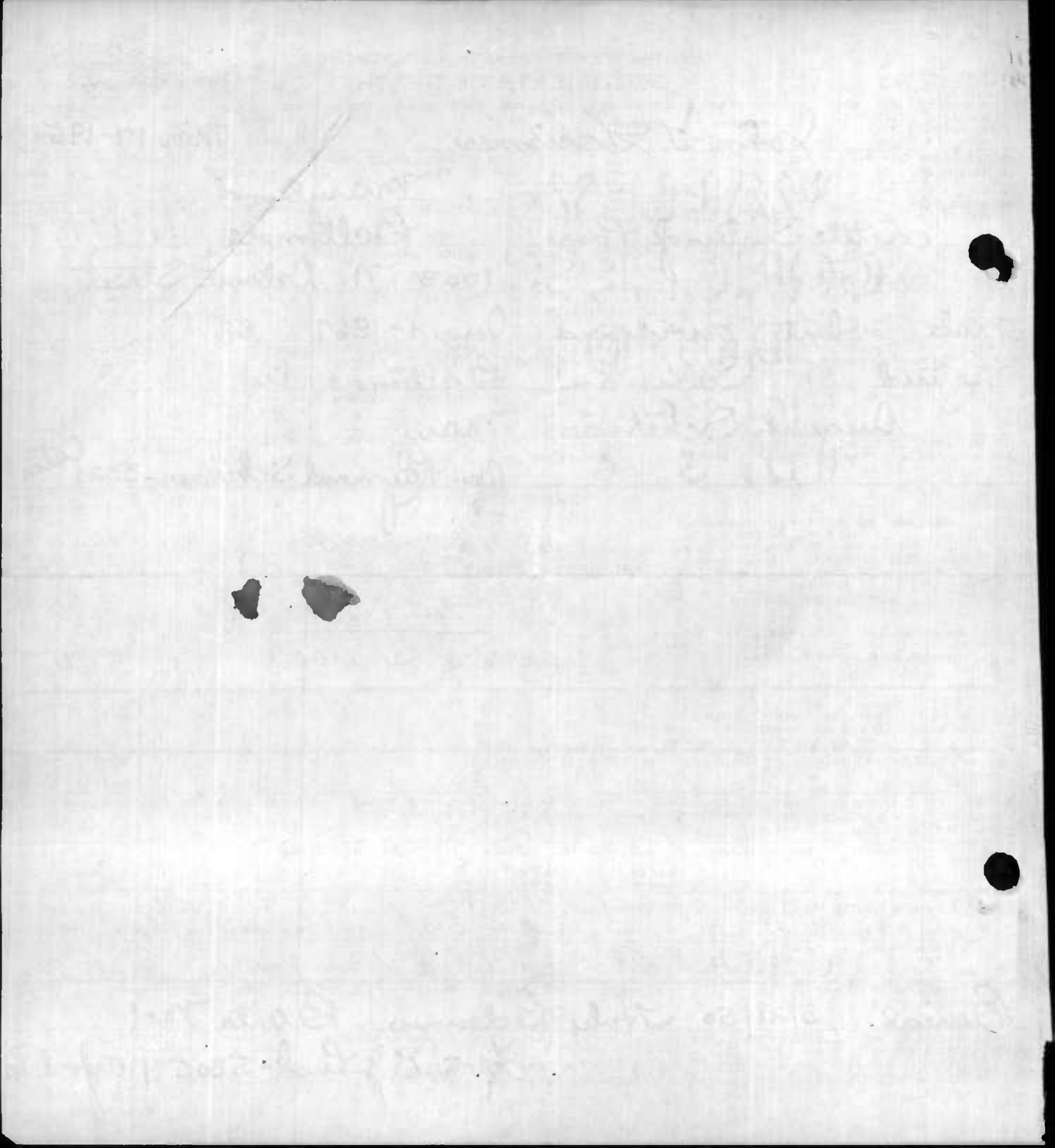
ADDRESS

MAR 20 1950

T. J. Williams

Leonard J. Luck - 5305 Hayford Rd







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. golley  
56050 2560

CERTIFICATE CORRECTED 4-10-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2560  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary A. Kummer

2. DATE  
OF  
DEATH

Mar 18-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

5506 Morello Rd

D. STREET ADDRESS (If rural, give location)

5506 Morello Road

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Oct 16-1865

9. AGE (in years last birthday)

84

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Charles Kummer - 5506 Morello

18. 4201

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1949, to 3/18, 1950, that I last saw the deceased alive on 3/18, 1950, and that death occurred at 11 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Thos. Golley

23B. ADDRESS

5702 Harford Rd

23C. DATE SIGNED

3/18/50

24. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/21/50

24C. NAME OF CEMETERY OR CREMATORY

Landon Park

24D. LOCATION (City, town, or county)

Balt Md

DATE RECEIVED BY LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

Walter H. Williams

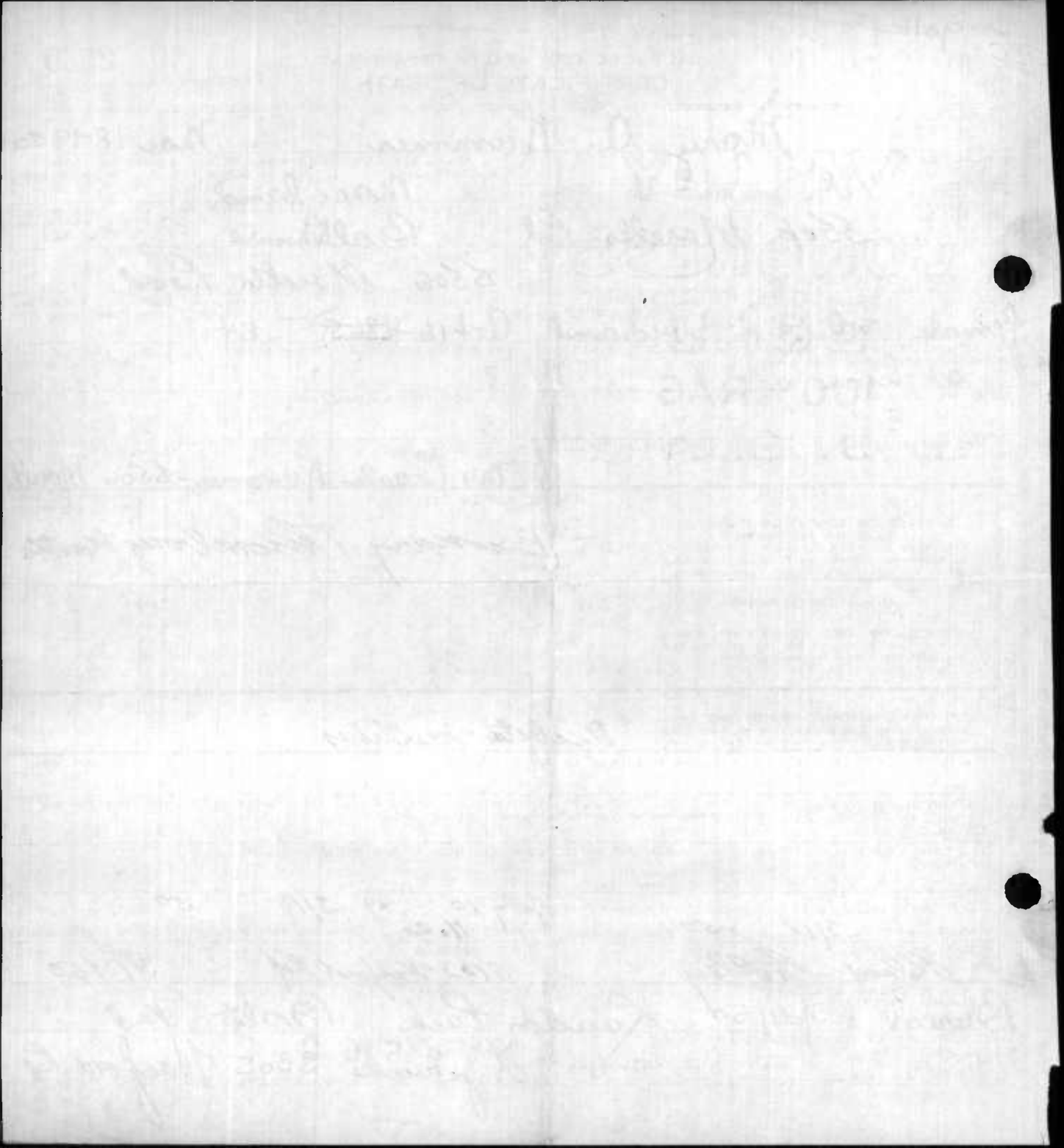
25. FUNERAL DIRECTOR

A. J. Luck

ADDRESS

5305 Harford Rd







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 2561

50 2561

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Peterson, Mrs. Louise

2. DATE  
OF  
DEATH

March 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Church Home Hosp.

C. Length of stay in Baltimore

16

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE (MARRIED)

WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Barthright, Warren

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

18.

416X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) \_\_\_\_\_  
DUE TO

Cerebral Embolus

INTERVAL BETWEEN  
ONSET AND DEATH

3-4 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

Mural Thrombus

many yrs

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) \_\_\_\_\_  
DUE TO

Rheumatic Heart Disease

many yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 5, 1950, to March 19, 1950, that I last saw the deceased alive on March 19, 1950, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Ronald L. Fisher

M.D.

23B. ADDRESS

Church Home Hosp.

23C. DATE SIGNED

March 19, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial March 22, 1950 Oak Lawn Cemetery Baltimore Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 20 1950

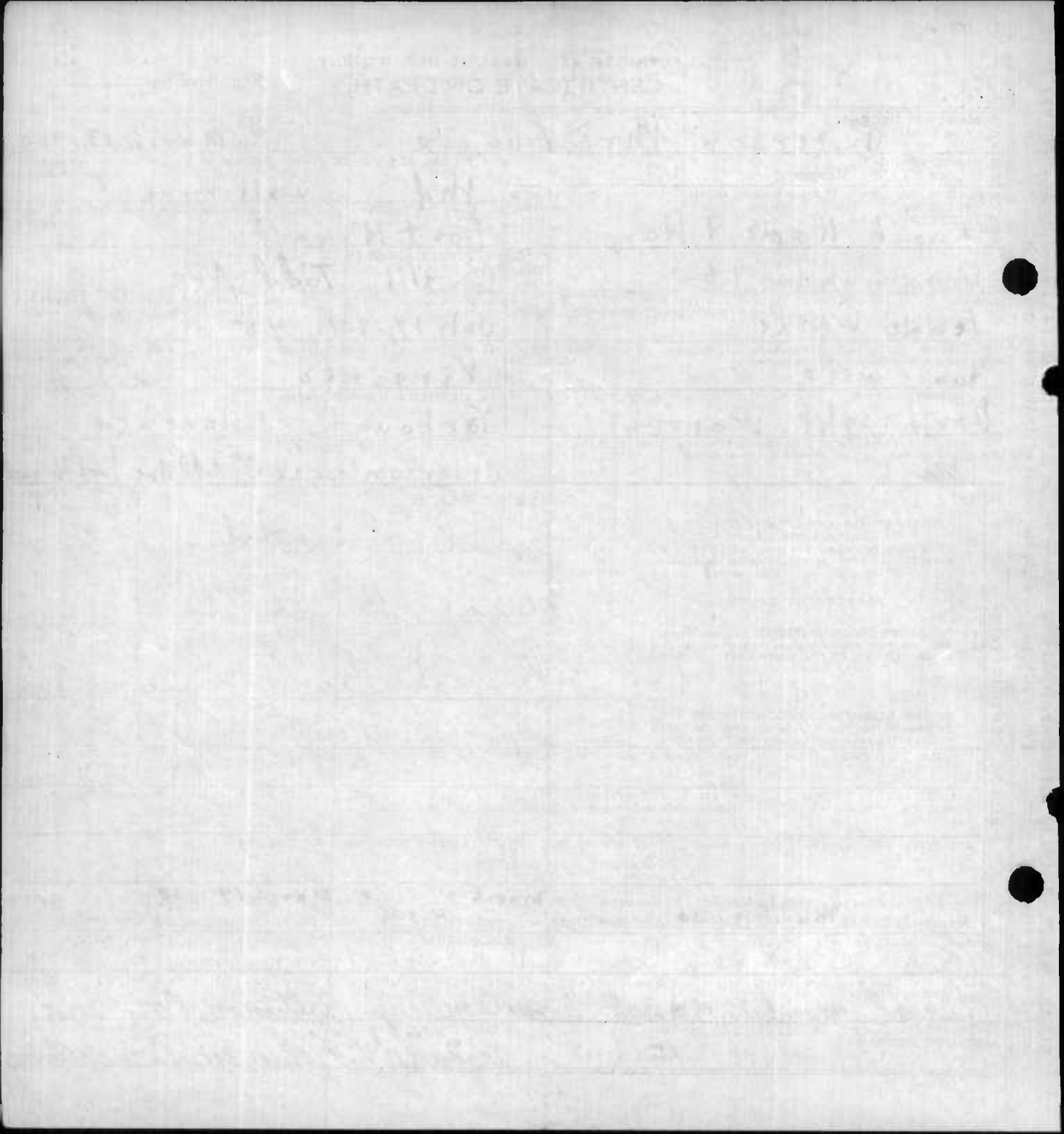
Integrator

Ronald L. Fisher, 2112 Dundalk Ave.

VS 150

95B







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alvah E. Wolfe

2. DATE  
OF  
DEATH

Mar. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hospital

C. Length of stay in Baltimore

30

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Locomotive Engineer

10B. KIND OF BUSINESS OR INDUSTRY

R.R. (B. & O.)

13. FATHER'S NAME

Jacurthn Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No -

16. SOCIAL SECURITY NO.

705-12-3751

17. INFORMANT

ADDRESS

Mrs. Esther L. Wolfe (wife) - Same

CAUSE OF DEATH

18. 470.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, J.

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☐

MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Mar. 18, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial -

24B. DATE

Mar. 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cem.

24D. LOCATION (City, town, or county) (State)

A. A. Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

Wm. H. Kammer, J.

25. FUNERAL DIRECTOR

925 E. Evans

ADDRESS

322475 - Charles H. Balt 30, Md



CERTIFICATE OF DEATH

1917

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

520  
50 2563

THOMAS

50 2563

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANKLIN

2. DATE  
OF  
DEATH

March 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore

30

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Electrical Engineer

13. FATHER'S NAME

George F. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No -

16. SOCIAL SECURITY NO.

218-10-6652

18. 561.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Prolonged toxemia

2 Mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

SUB-PHRENIC ABSCESS

7 weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INCARCERATED INGUINAL HERNIA

9 weeks

19A. DATE OF OPERATION(S)

1-2-50 2-12-50

19B. MAJOR FINDINGS OF OPERATION

INGUINAL HERNIA

A.) INCARCERATED Right

B.) LEFT SUB-PHRENIC ABSCESS

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

None

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

-

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

-

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

-

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

-

22. I hereby certify that I attended the deceased from 1-20, 1950, to 3-18, 1950, that I last saw the deceased alive on 3-18, 1950, and that death occurred at 4:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Daniel J. Birmingham

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-21-50

24C. NAME OF CEMETERY OR CREMATORY

Greenwood

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 20 1950

REGISTRAR'S SIGNATURE

John H. Williams

25. FUNERAL DIRECTOR

Charles B. Law, 802 Mad. Ave.

ADDRESS



DEPARTMENT OF HEALTH

STATE

NO. 1000  
1900

1900

DEPARTMENT OF HEALTH

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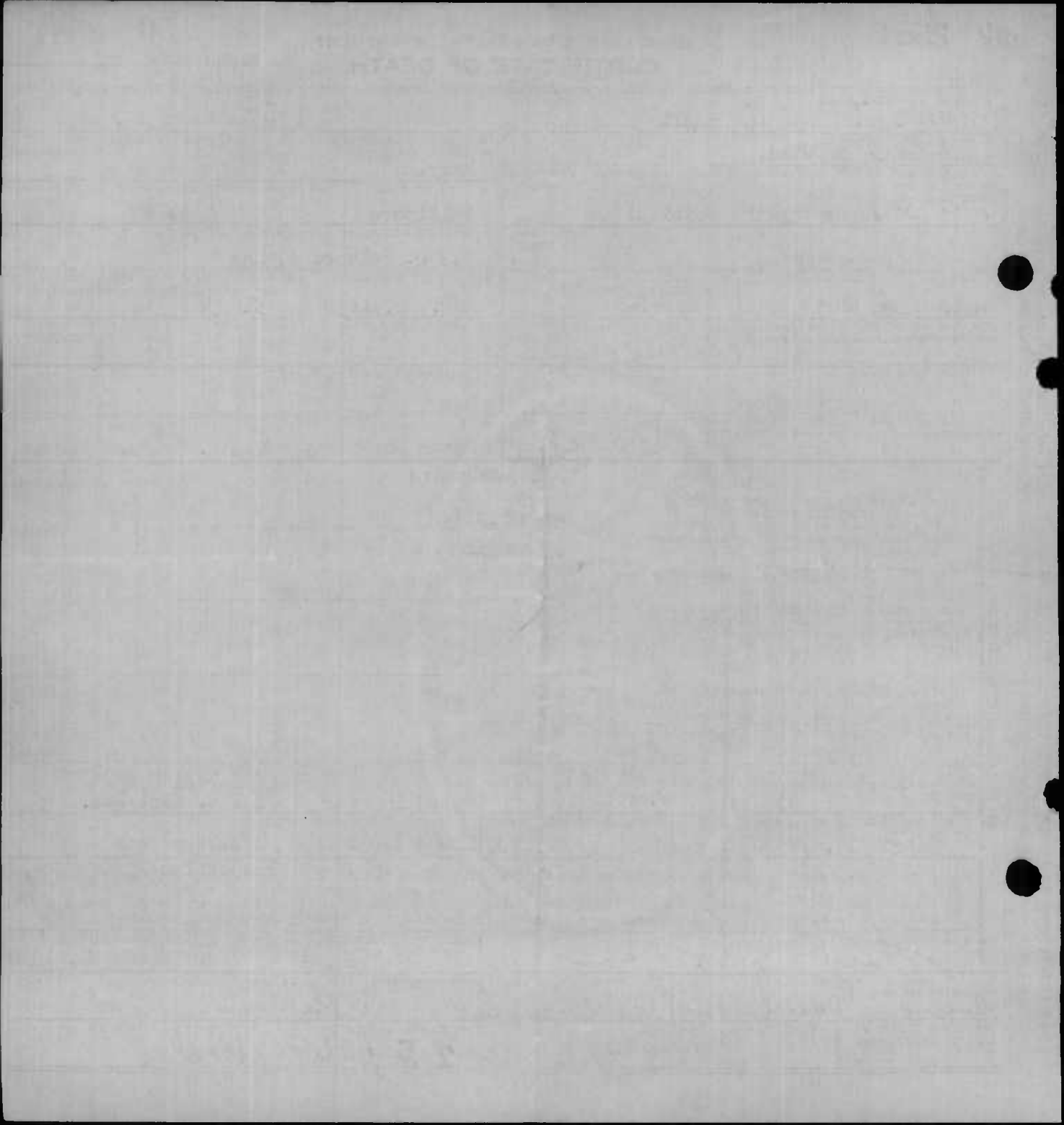
DEPARTMENT OF HEALTH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

2564		BALTIMORE CITY HEALTH DEPARTMENT		50 2564	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>GEORGE J DOUGHERTY</b>			2. DATE OF DEATH <b>March 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>913 S. Belnord Avenue</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug. 28, 1898</b>	9. AGE (in years last birthday) <b>51</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - BARREL</b>			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George Dougherty</b>			14. MOTHER'S MAIDEN NAME <b>Mary ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>218-18-8131</b>		
17. INFORMANT <b>Susan Dougherty</b>			ADDRESS <b>913 S. Belnord Avenue</b>		
18. <b>E974</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxiation</b> DUE TO <b>hanging</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>storehouse</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Garrett Barrel Company shed in rear of 1201 S. East Ave.</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>March 19, 1950 ?</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Hanged self from rafter by rope</b>	
22. I certify that I took charge of the remains described above, held an <b>Inquiry &amp; Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Paul L. Royer</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>March 20, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 22, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mid-Carmel</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		24E. FUNERAL DIRECTOR <b>George W. Weber</b>			
24F. DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		24G. REGISTRAR'S SIGNATURE <b>George W. Weber</b>		24H. ADDRESS	
VS 151 <b>N-991 98810 164a</b>					







PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

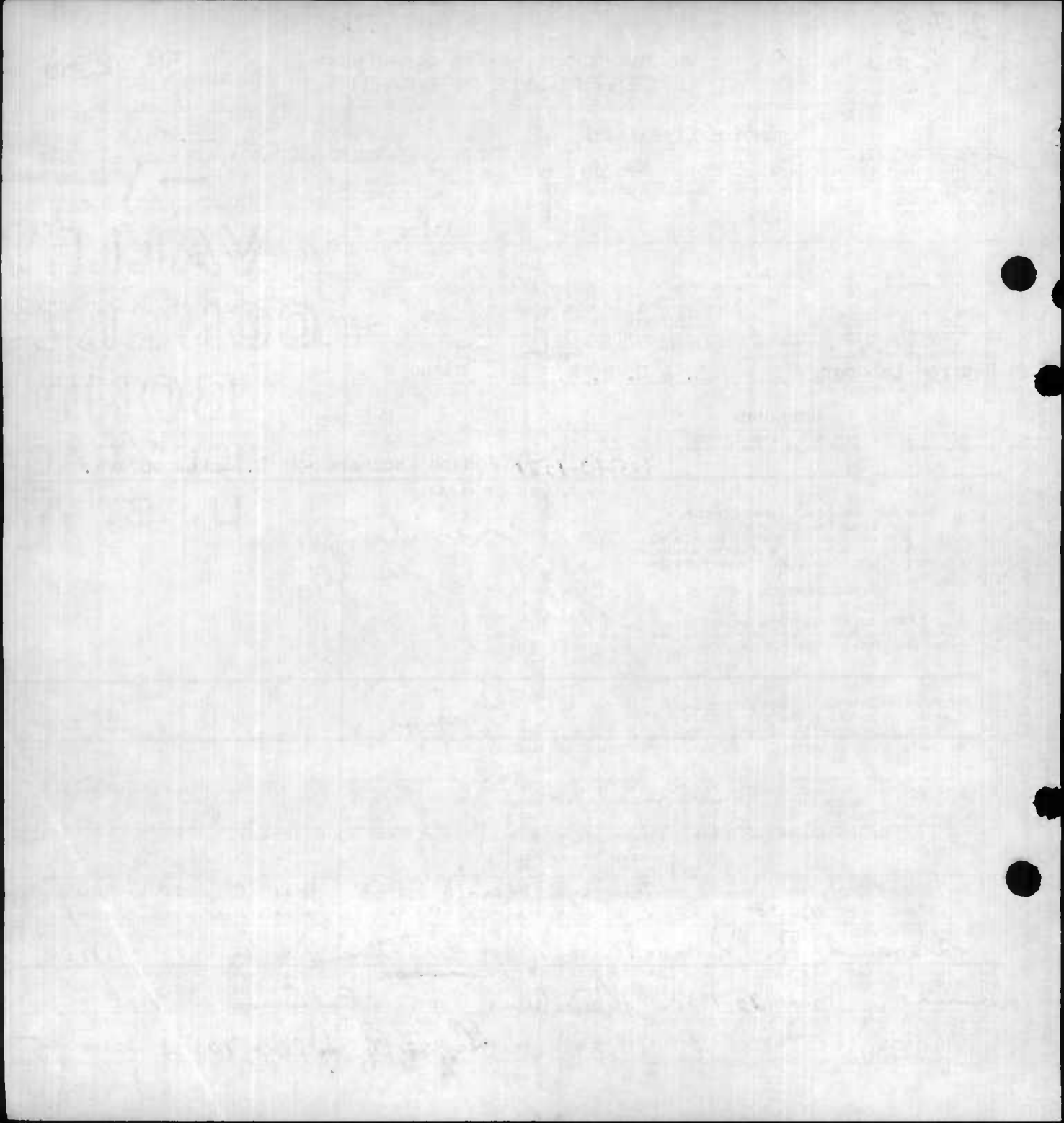
C-245  
50 2565

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2565

BIRTH NO.		
1. NAME OF DECEASED (Type or Print) Ignatius Cieslinski		2. DATE OF DEATH Mar. 19, 1950
3. PLACE OF DEATH: A. Baltimore City, Maryland 925 South Kenwood Ave B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
C. Length of stay in Baltimore Yrs. Mos. Days		5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24
6. D. STREET ADDRESS (If rural, give location) 925 South Kenwood Ave		7. AGE (In years last birthday) 77
8. SEX Male	9. COLOR OR RACE White	10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		12. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-1521
17. INFORMANT Jodeph Kaczmarek-28 N. Lakewood Ave.		18. ADDRESS
18. 481 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Senility (old age) DUE TO ANTECEDENT CAUSES (B) DUE TO (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Grippes Interval between onset and death Week		
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Mar. 16, 1950, to Mar. 18, 1950, that I last saw the deceased alive on Mar. 18, 1950, and that death occurred at 5:17 a.m., from the causes and on the date stated above.		
23A. SIGNATURE Segmund R. Nowak M. D.		23B. ADDRESS 408 S. Patterson Park Gr.
23C. DATE SIGNED 3/19/50		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE March 20 1950	24C. NAME OF CEMETERY OR CREMATOR St. Stanislaus
24D. LOCATION (City, town, or county) Baltimore		(State) Md
DATE RECEIVED BY LOCAL REGISTRAR MAR 20 1950	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR George R. Weber 705 S. Green St







PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

B-635  
50 2566

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2566

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ANNIE T. BARTON

2. DATE  
OF  
DEATH

Mar. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

909 De Soto Rd

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Sept. 12, 1865

9. AGE (In years  
last birthday)

84

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired Seamstress

10B. KIND OF BUSINESS OR  
INDUSTRY

Shirt Mfr.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel J. Barton

14. MOTHER'S MAIDEN NAME

Annie E. Collier

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. Blanche Hargest 909 De Soto Rd.

18. 331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

cerebral hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension; Gen. Arteriosclerosis

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from March 11, 1950, to March 18, 1950, that I last saw the deceased alive on 3-18, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Nathan Rausin

23B. ADDRESS

M. D.

206 S. Gilman St.

23C. DATE SIGNED

3-20-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/21/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

W. S. TUCKER & SONS

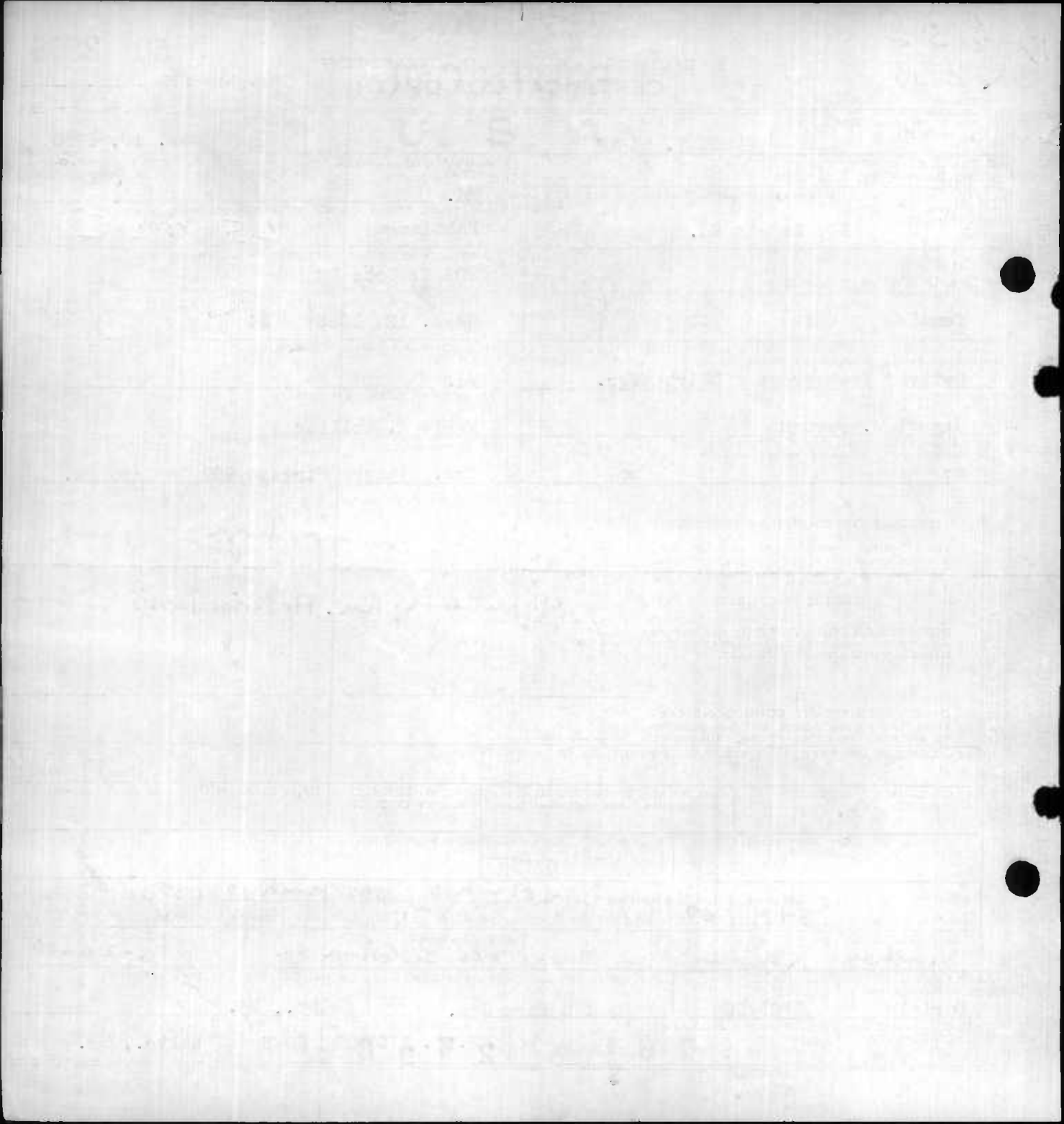
Balto., Md.

MAR 20 1950

VS 150

83a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 2567

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CERTIFICATE CORRECTED  
Patricia Yealdhall

2. DATE  
OF  
DEATH

3-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or series of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(A) Fracture of Skull  
DUE TO Fracture of Pelvis

(B)

DUE TO

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

19 Mar 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

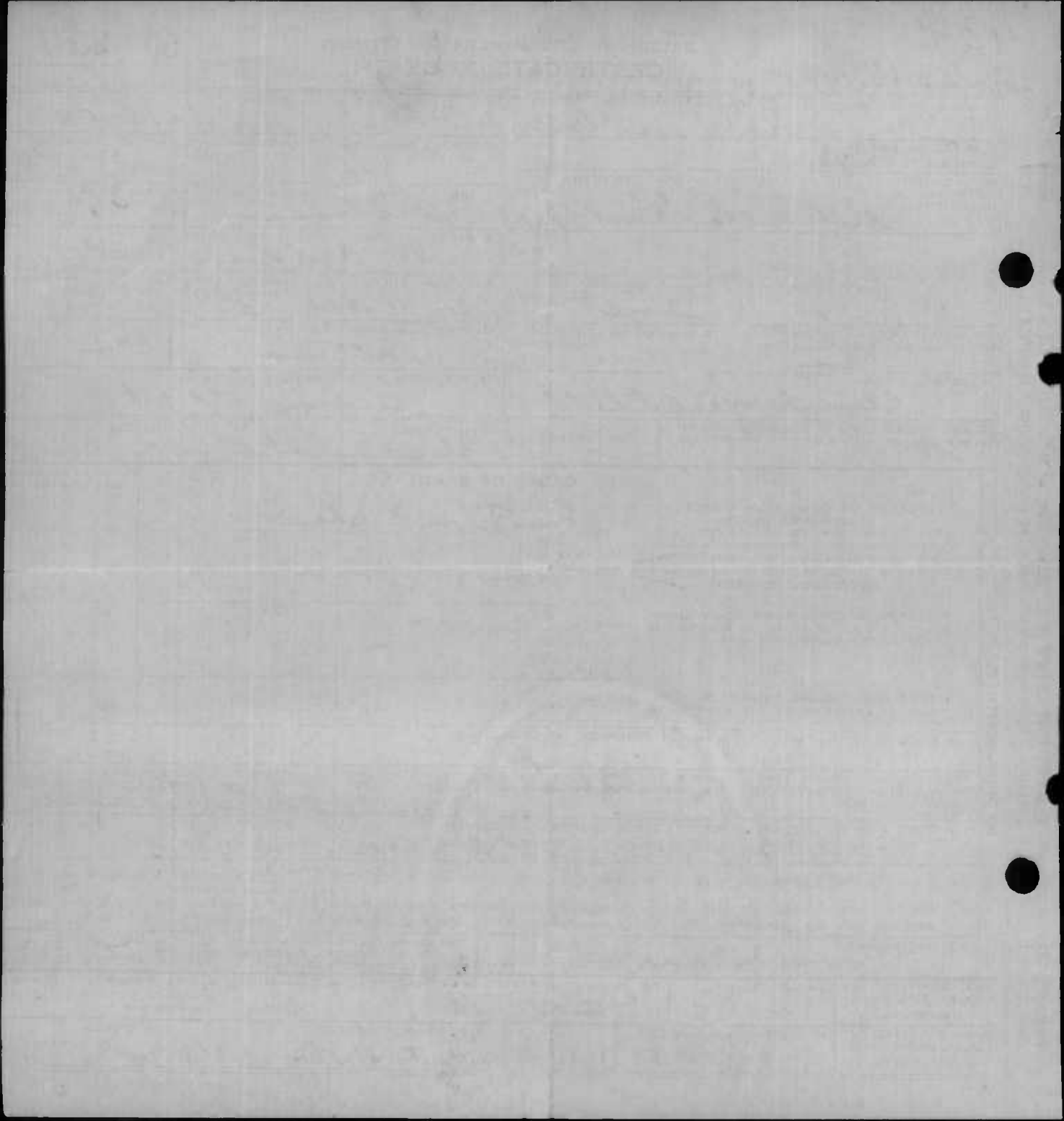
ADDRESS

VS 151

N-804.2

1700







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

600

FREY

50 2568

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

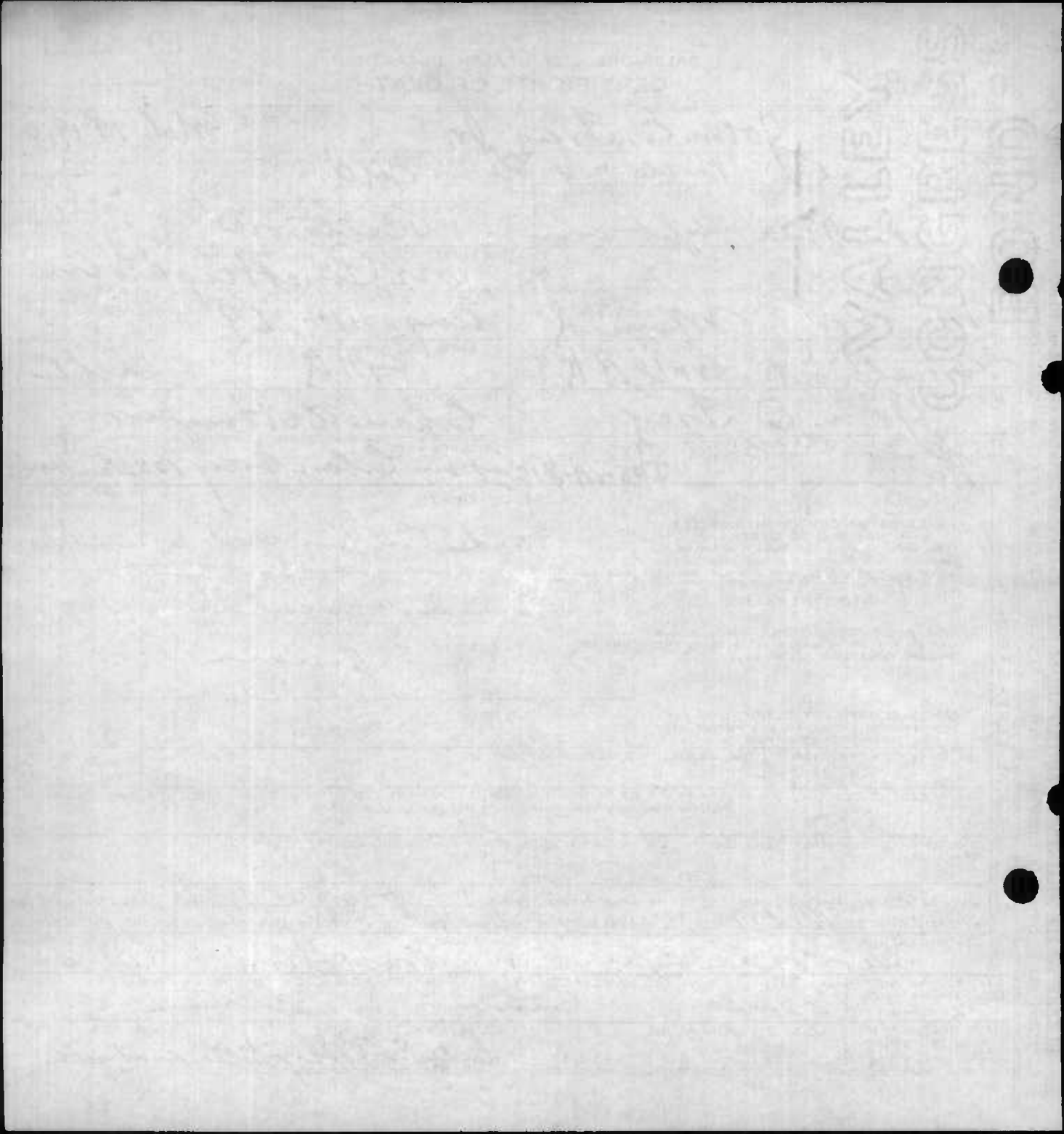
1. NAME OF DECEASED (Type or Print) <b>John E. Frey Jr.</b>			2. DATE OF DEATH <b>Mar 19 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Md</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>1022 Pine Hgts Ave</b>			6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 25-018</b>		
7. Length of stay in Baltimore <b>2</b>			8. STREET ADDRESS (If rural, give location) <b>1022 Pine Hgts Ave</b>		
9. SEX <b>M</b>	10. COLOR OR RACE <b>W</b>	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	12. DATE OF BIRTH <b>Aug 20 1880</b>		13. AGE (in years last birthday) <b>69</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			15. KIND OF BUSINESS OR INDUSTRY <b>B+C R R</b>		16. BIRTH PLACE (State or foreign country) <b>Md</b>
17. FATHER'S NAME <b>John E Frey</b>			18. MOTHER'S MAIDEN NAME <b>Charlotte Humphrey</b>		
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			20. SOCIAL SECURITY NO. <b>705-09-818</b>		21. INFORMANT <b>Mrs Clara Frey</b>
22. ADDRESS (If yes, give war or dates of service) <b>1022 Pine Hgts Ave</b>			23. ADDRESS <b>1022 Pine Hgts Ave</b>		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute cardiac failure</b>			19. CAUSE OF DEATH <b>sudden</b>		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary vascular disease</b>			21. INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
23. DATE OF OPERATION <b>0</b>		24. MAJOR FINDINGS OF OPERATION		25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. ACCIDENT, SUICIDE, HOMICIDE (Specify)		27. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I hereby certify that I attended the deceased from <b>Jan 1</b> , 19 <b>49</b> , to <b>Mar 19</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Mar 17</b> , 19 <b>50</b> , and that death occurred at <b>4 P</b> m., from the causes and on the date stated above.					
33. SIGNATURE <b>Leo M. Kieffer</b>		34. ADDRESS <b>2470 East Blvd</b>		35. DATE SIGNED <b>Mar 20 50</b>	
36. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		37. DATE <b>3-22-50</b>		38. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>	
39. LOCATION (City, town, or county) <b>Baltimore</b>		40. DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		41. REGISTRAR'S SIGNATURE <b>Wm. J. H. H. H.</b>	
42. FUNERAL DIRECTOR <b>Seay &amp; H. H. H.</b>		43. ADDRESS <b>Seay &amp; H. H. H.</b>		44. VS 150	

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937







should be carefully supplied. The Every item of information should be written clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

636

CERTIFICATE CORRECTED

3-22-50

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BALTIMORE CITY HEALTH DEPARTMENT

50

2569

BIRTH NO.

CARDARELLI

CERTIFICATE OF DEATH

Registered No.

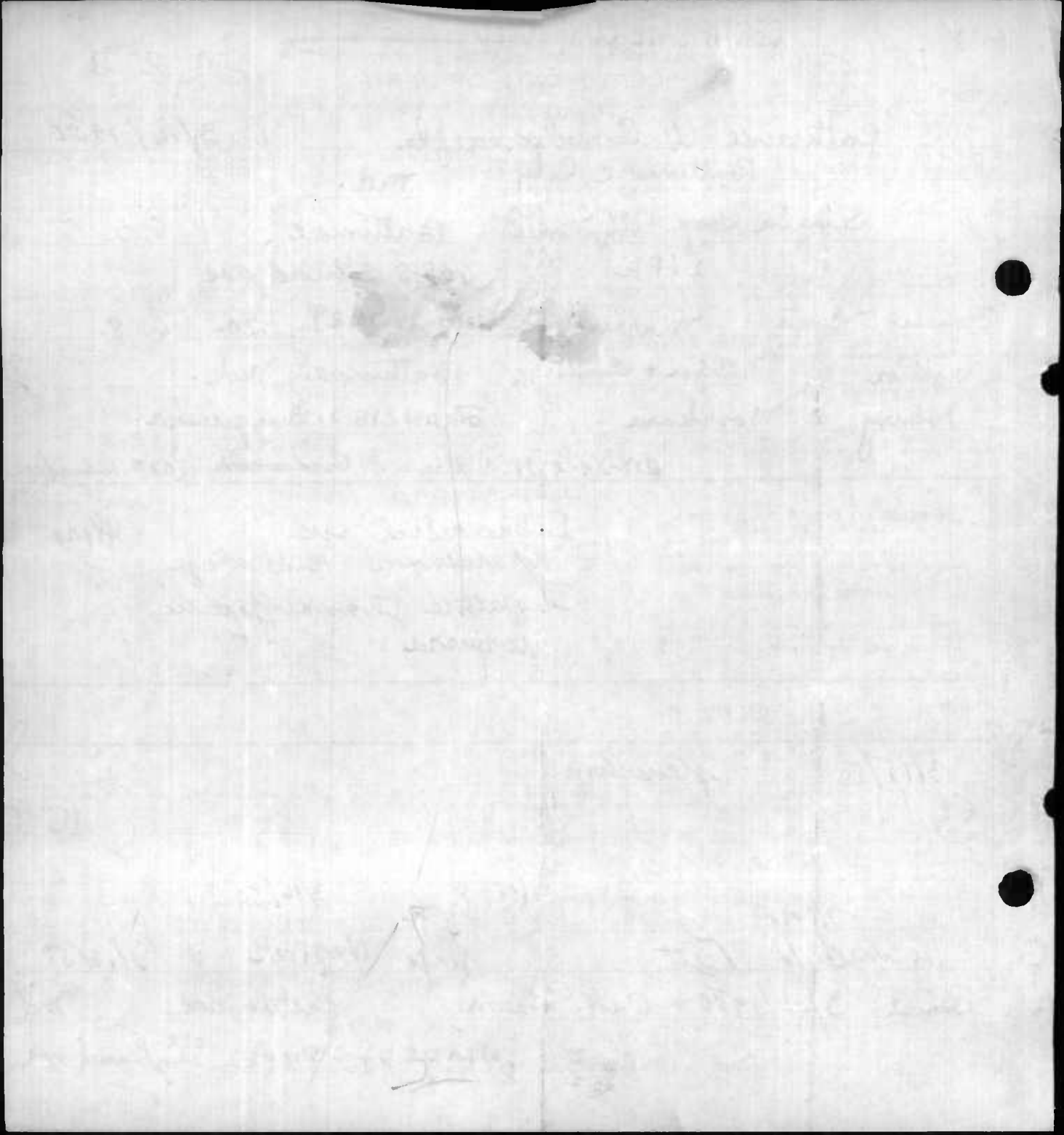
1. NAME OF DECEASED (Type or Print) <b>Catherine A. Cardarelli</b>		2. DATE OF DEATH <b>3/16/1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>Baltimore City</b>		4. USUAL RESIDENCE (Where deceased lived, if in institution: residence before admission) a. STATE <b>md.</b> b. COUNTY	
b. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) <b>Sinia Hosp. 1700 E Monument</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 1-03</b>	
Length of stay in Baltimore <b>LIFE</b>		d. STREET ADDRESS (If rural, give location) <b>408 S. Belmont ave</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug 28, 1929</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Biger + Cimbuge</b>	9. AGE (in years last birthday) <b>20</b> 11 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry J. Worsham</b>		14. MOTHER'S MAIDEN NAME <b>FRANCIS J. Bungerska</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-24-4789</b>	
17. INFORMANT <b>William H. Cardarelli</b>		ADDRESS <b>408 S. Belmont ave</b>	
18. <b>298.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intracerebral and subarachnoid hemorrhage</b>		CAUSE OF DEATH (A) <b>Intracerebral and subarachnoid hemorrhage</b> DUE TO (B) <b>Disipathic (thrombocytopenic) purpura</b> DUE TO (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION <b>3/15/50</b>		19b. MAJOR FINDINGS OF OPERATION <b>Splenectomy</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/15/50</b> , 19 <b>50</b> , to <b>3/16/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3/16/50</b> , 19 <b>50</b> , and that death occurred at <b>3 p. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Howard H. Post</b>		23b. ADDRESS <b>Sinia Hospital</b>	
23c. DATE SIGNED <b>3/16/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>3/21/1950</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		24d. LOCATION (City, town, or county) (State) <b>Eastern ave. Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 20 1950</b>		25. FUNERAL DIRECTOR <b>HENDELY L. DIPPEN</b>	
REGISTRAR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>312 S. Highland ave.</b>	

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635 CERTIFICATE CORRECTED 3-30-50 X				BALTIMORE CITY HEALTH DEPARTMENT		50 2570	
BIRTH NO. 50 2570				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Chandler B. Gardiner</i>				2. DATE OF DEATH <i>March 19, 1950</i>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Harford</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Abertown</i> <i>6-200</i>			
D. STREET ADDRESS (If rural, give location) <i>R.D. #1</i>							
5. SEX <i>male</i>				6. COLOR OR RACE <i>white</i>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>				8. DATE OF BIRTH <i>2-22-14</i>			
9. AGE (In years last birthday) <i>36</i>				10. UNDER 1 Year Months: Days			
11. UNDER 24 Hours Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanical Engineer U.S. Govt</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTH PLACE (State or foreign country) <i>Mass</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>George C. Gardiner</i>				14. MOTHER'S MAIDEN NAME <i>Mabel L Brewer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>				ADDRESS			
18. <i>057.0</i>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH <i>56 hrs</i>			
(A) <i>Meningeal meningitis</i>							
DUE TO							
ANTECEDENT CAUSES							
(B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
(C)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Multiple myeloma</i>				<i>2 yrs</i>			
19A. DATE OF OPERATION <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <i>2-27</i> , 19 <i>50</i> , to <i>3-19</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-17</i> , 19 <i>50</i> , and that death occurred at <i>12:05</i> p.m., from the causes and on the date stated above.							
23A. SIGNATURE <i>Frank C. Brown Jr.</i>				23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
M. D.				23C. DATE SIGNED <i>3/29/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>				24B. DATE <i>3/21/50</i>			
24C. NAME OF CEMETERY OR CREMATORY <i>Lakeside</i>				24D. LOCATION (City, town, or county) (State) <i>Wakefield Mass</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 20 1950</i>				REGISTRAR'S SIGNATURE <i>Frank C. Brown Jr.</i>			
25. FUNERAL DIRECTOR <i>William C. Brown</i>				ADDRESS <i>1217 St Paul</i>			
VS 150				V 22 97			
				6			



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2571  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Philip E. Panzer*

2. DATE  
OF  
DEATH

*March 17, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *918 E. Madison St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. Length of stay in Baltimore

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

B. DATE OF BIRTH

*June 28, 1902*

9. AGE (in years last birthday)

*47*

11 Under 1 Year Months: Days

*8 18*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Baker*

10B. KIND OF BUSINESS OR INDUSTRY

*Bread Bakery*

11. BIRTHPLACE (State or foreign country)

*Baltimore*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*John Panzer*

14. MOTHER'S MAIDEN NAME

*Anna Hamburger*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or or unknown) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

*Kearrie Panzer*

ADDRESS

18. *163 X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Carcinoma of right lung*

DUE TO

*3 months*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 10*, 1950, to *March 17*, 1950, that I last saw the deceased alive on *3/17*, 1950, and that death occurred at *9 P* m., from the causes and on the date stated above.

23A. SIGNATURE

*Joseph Pokorny*

M. D.

23B. ADDRESS

*2200 E Madison St*

23C. DATE SIGNED

*3/19/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*3-21-50*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer*

24D. LOCATION (City, town, or county)

*Baltimore Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 20 1950*

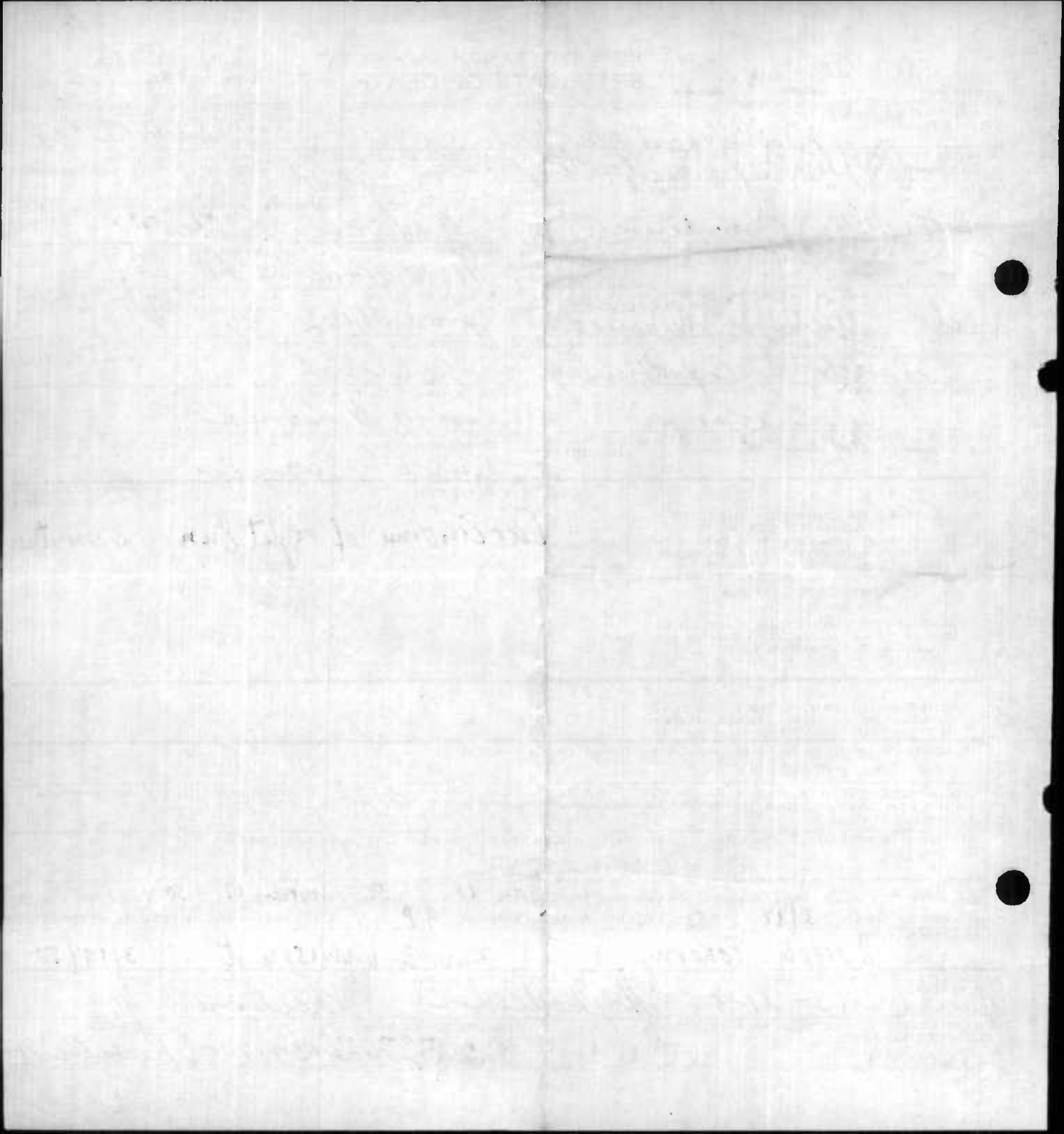
*VS 150*

*22 E Madison St 900 E Chester St*

300XV

47D







160 50 2572

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2572

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Ethel Nopper*

2. DATE  
OF  
DEATH

*3/20/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*St. Josephs Hospital*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*F*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED,

~~WIDOWED, DIVORCED~~ (Specify)

*Married*

8. DATE OF BIRTH

*2/2/02*

9. AGE (In years  
last birthday)

*48*

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Own Home*

11. BIRTHPLACE (State or foreign country)

*Balto. Md.*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Conrad Binau*

14. MOTHER'S MAIDEN NAME

*Mary A. Hamilton*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Chas. Nopper 1411 Light St*

18. *174X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) *Anterograde C.V. Disease*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Pericarditis of Uterus*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*P. J. Lumb*

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

*3/20/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/23/50*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer*

24D. LOCATION (City, town, or county)

*Balto. Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*H. J. Williams, Jr.*

25. FUNERAL DIRECTOR

ADDRESS

*4507 K Ave. 1217 St. Paul St.*



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK



PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

220

50 2573

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2573

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ALICE E. SYKES

2. DATE  
OF  
DEATH

Mar. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1009 S. Linwood Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1009 S. Linwood Ave.

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Oct. 8, 1871

9. AGE (in years  
last birthday)

78

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Baltimore Co., Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Zackriah Corns

14. MOTHER'S MAIDEN NAME

Rebecca (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, oo or uokooow) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Emma Kraisser, 1009 S. Linwood Ave.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) *Cardiac Decomposition*  
DUE TO

1 wk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Senile Arteriosclerosis, Hardened.*  
DUE TO

8 yrs.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.*Chronic Pneumonia*

3 wks.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from *Mar 5*, 1950, to *Mar 18*, 1950, that I last saw the  
deceased alive on *Mar. 17*, 1950, and that death occurred at *2:25 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Clara W. L. Pious*

M. O.

23B. ADDRESS

*3022 Eastern Ave.*

23C. DATE SIGNED

*3/20/50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/21/50

24C. NAME OF CEMETERY OR CREMATORY

Zion Lutheran

24D. LOCATION (City, town, or county) (State)

Stemmers Run, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William Cook, Inc.*

25. FUNERAL DIRECTOR

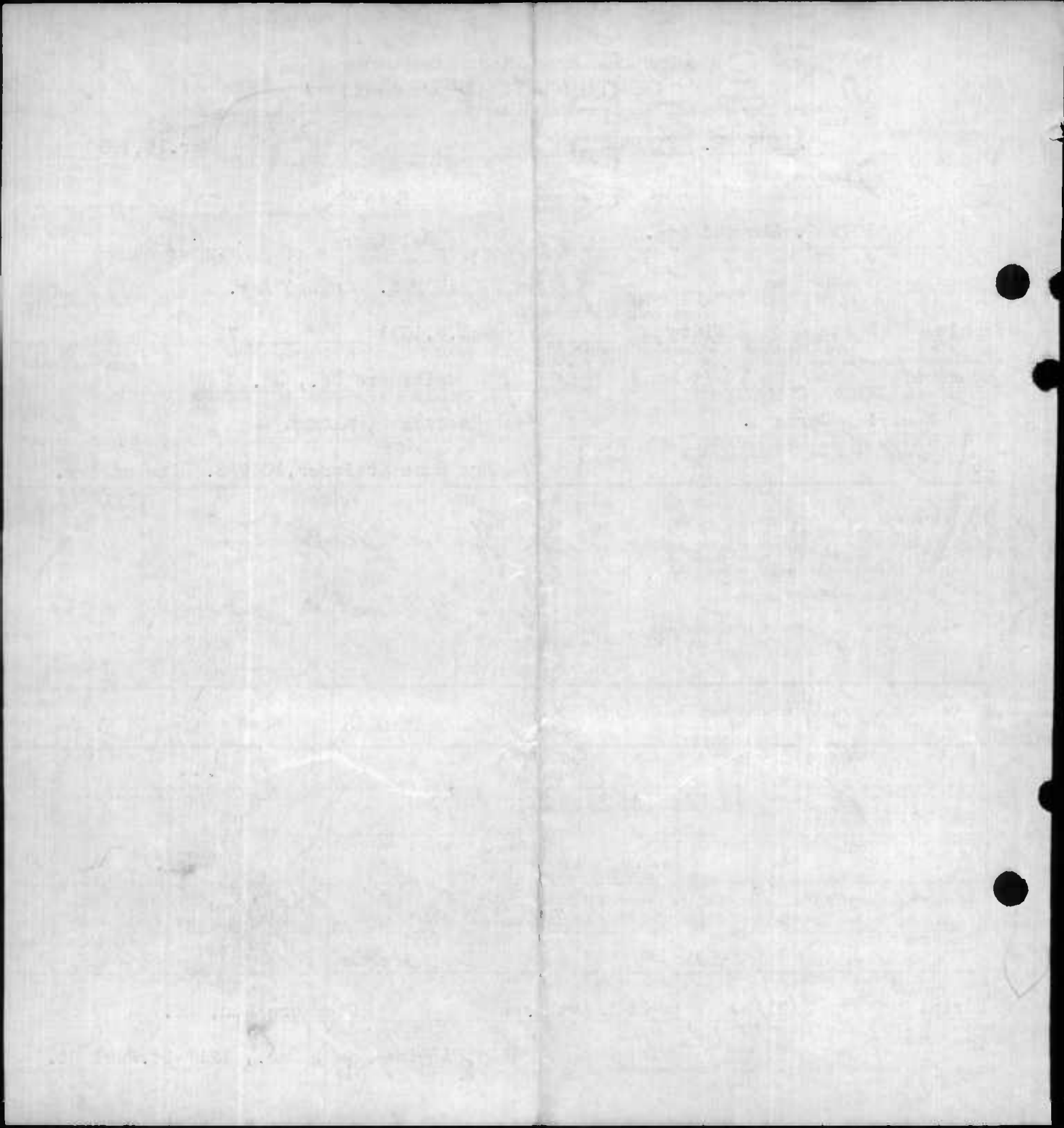
ADDRESS

William Cook, Inc., 1217 St. Paul St.

MAR 19 1950

95C







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

50 2574

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2574  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SADIE R. ROBINSON

2. DATE  
OF

DEATH March 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland

C. CITY OR TOWN

Baltimore

O. STREET ADDRESS (If rural, give location)

1707 Harford Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 23, 1890

9. AGE (in years  
last birthday)

60

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George W. Rodgers

14. MOTHER'S MAIDEN NAME

Rose Gaines

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

George Robinson, 1707 Harford Ave.

18. 490x I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

ONE TO

ANTECEDENT CAUSES

(B)

ONE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 17, 1950, to Mar. 19, 1950, that I last saw the deceased alive on Mar. 19, 1950, and that death occurred at 6:45 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Linden

M. O.

23B. ADDRESS

14 S. Broadway

23C. DATE SIGNED

Mar. 20, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/22/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park,

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRY

MAR 21 1950

REGISTRAR'S SIGNATURE

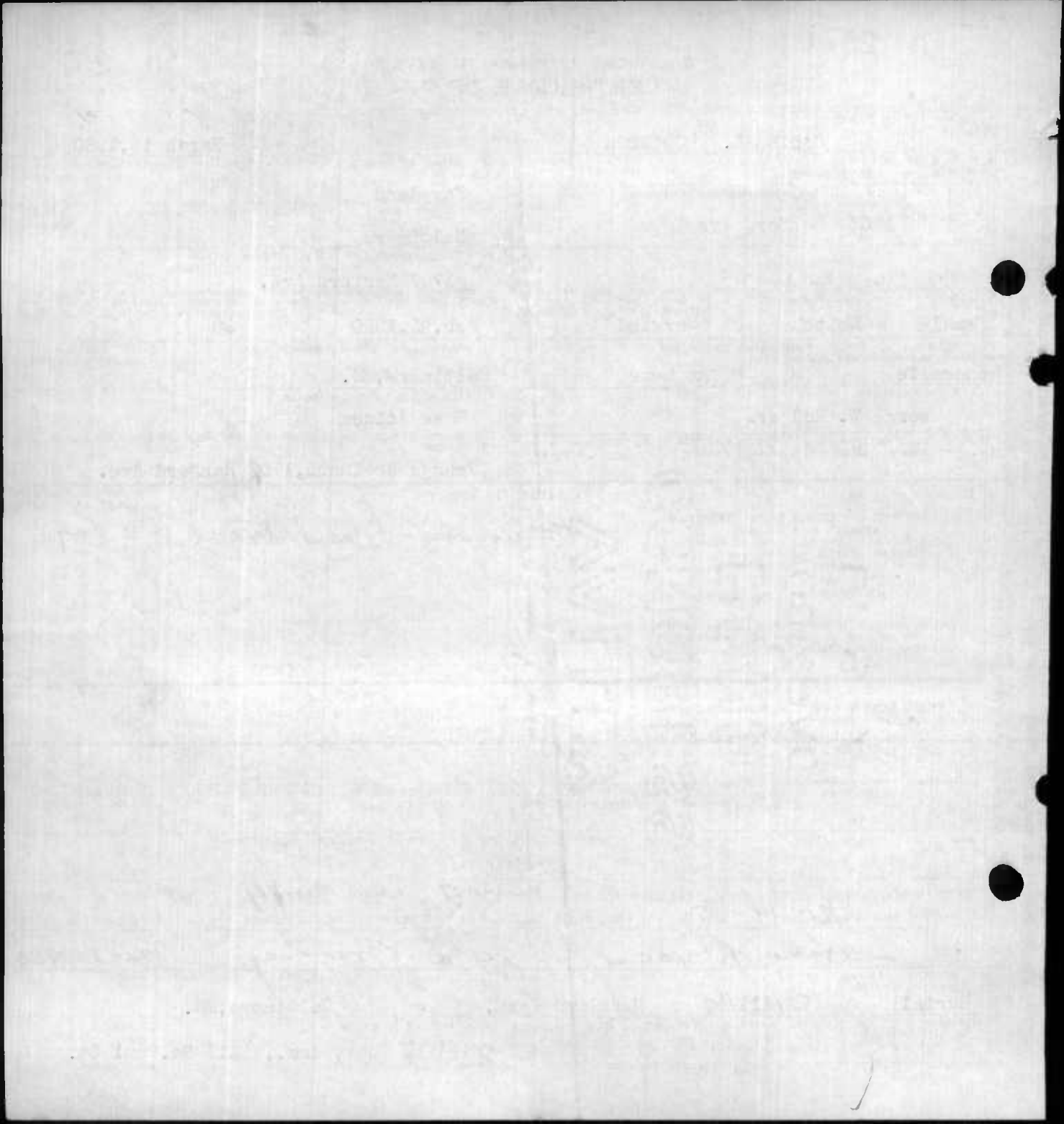
Harry Linden

25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.







3 2 60 50 2575  
The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

WILSON A. BAKER

2. DATE  
OF  
DEATH

March 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2403 Sherwood Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2403 Sherwood Ave.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 20, 1918

9. AGE (in years last birthday)

31

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Checker, unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Glen L. Martin Co

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jerome Baker

AIRPLANE (M)

14. MOTHER'S MAIDEN NAME

Viola (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Helen Owings, 534 East 27th St.

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis, pulmonary, bilateral  
DUE TO

6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 10, 1950, to Mar. 20, 1950, that I last saw the deceased alive on Mar. 19, 1950, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/22/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 21 1950

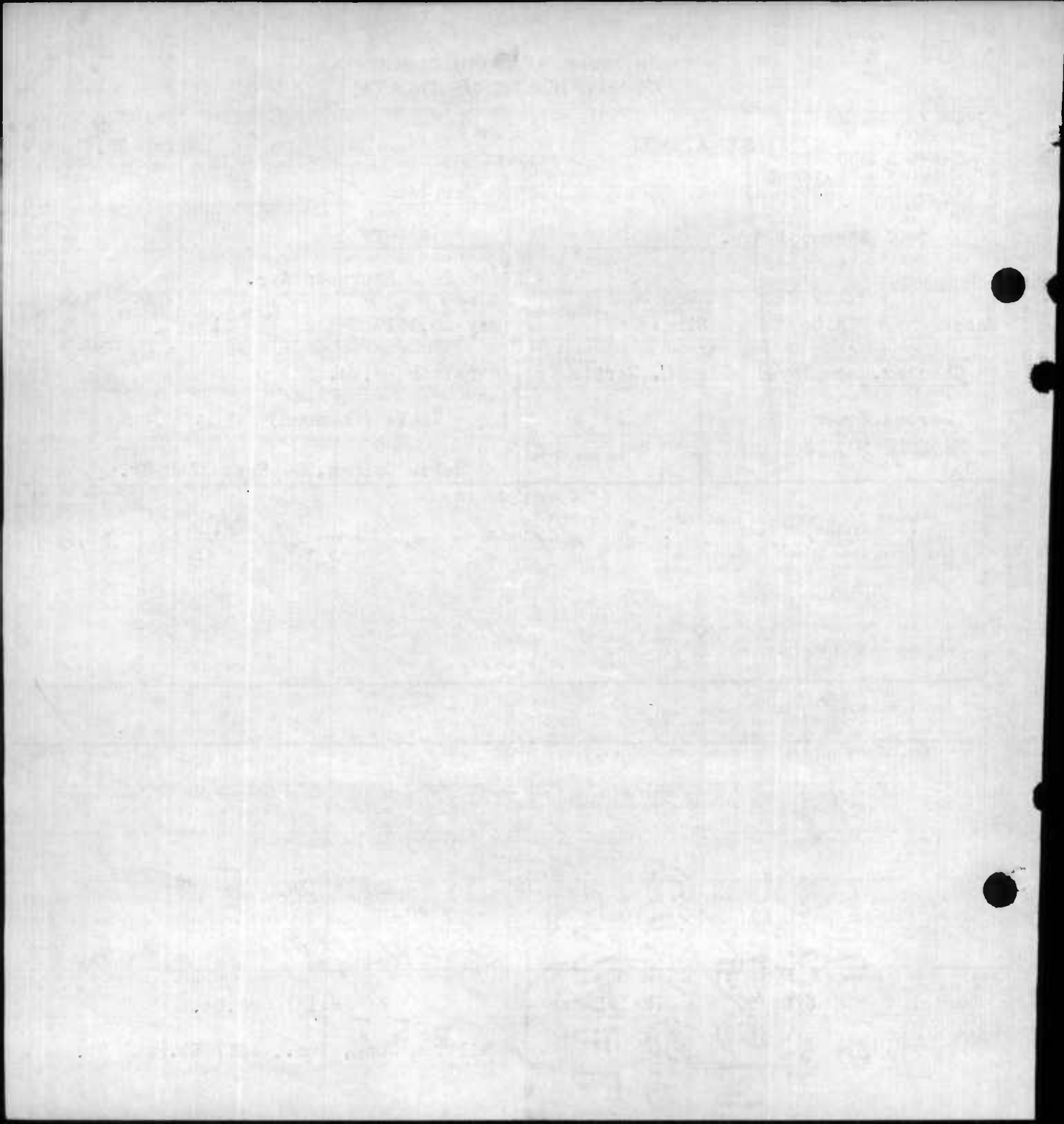
William Cook, Inc., 1217 St. Paul St.

49638

VS 150

136







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

50 2576

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2576

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SUSAN A. MONROE

2. DATE  
OF  
DEATH

Mar. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5723 Kavon Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION

5723 Kavon Ave.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

Dec. 18, 1867

9. AGE (in years last birthday)

82

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10B. KIND OF BUSINESS OR INDUSTRY  
At home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Boston

14. MOTHER'S MAIDEN NAME

(Unknown) Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miss Luray Monroe, 5723 Kavon Ave.

18. 480X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Broncho Pneumonia

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Infection

3 days

(C)

Chronic Bronchitis & Emphysema

10 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 14, 1950, to Feb 20, 1950, that I last saw the deceased alive on Feb 19, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

554 Stearns M. D.

2878 Stanford Rd

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR  
MAR 21 1950

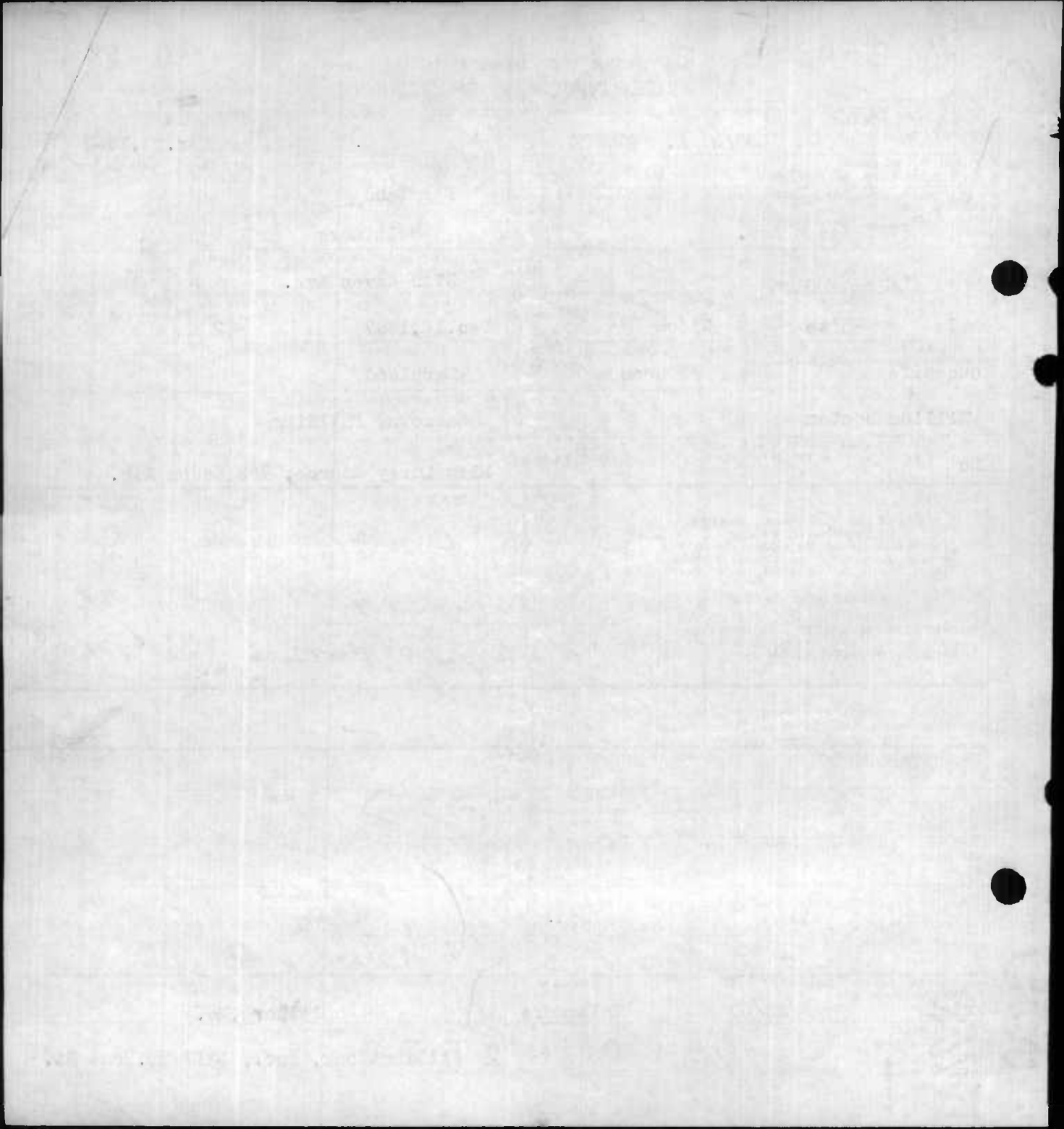
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

2 William Cook, Inc., 1217 St. Paul St.







3 430  
The cause of death should be carefully supplied. The physician should be especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2577  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEONARD J. BELT

2. DATE  
OF  
DEATH

Mar. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE  
Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

00 400 S. Bentalou St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 20-05

D. STREET ADDRESS (If rural, give location)

400 S. Bentalou St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1882

9. AGE (in years  
last birthday)

67

If Under 1 Year Months: Days: Hours: Min

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Conductor, Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

(B & O) R.R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Leonard J. Belt

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war, or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Leonard L. Belt, 400 S. Bentalou St.

18. 152X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Sarcoma, Pelvis*  
DUE TO  
(primary site: right ileum)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) .....  
DUE TO  
(C) .....

INTERVAL BETWEEN  
ONSET AND DEATH

3 years

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov.*, 19*49*, to *Mar.*, 19*50*, that I last saw the  
deceased alive on *3/18*, 19*50*, and that death occurred at *m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Walter Lohm*

M. D.

23B. ADDRESS

*112 E Fort Ave 30*

23C. DATE SIGNED

*3/20/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

*MAR 21 1950*

REGISTRAR'S SIGNATURE

*Walter Lohm*

25. FUNERAL DIRECTOR

*William Cook, Inc., 1217 St. Paul St.*

ADDRESS

VS 150

102 47

46 E



Was this order around  
if true?

See Document File

50-2577

4-19-50

ES



correct age is especially important. Physicians: please write the causes of death clearly and briefly. Every item of information should be carefully supplied. The

50 2578

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2578

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eva Krause

2. DATE  
OF  
DEATH 3-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE  
Maryland

B. COUNTY  
City

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION 1521 Clarkson Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 23-02

D. STREET ADDRESS (If rural, give location)  
1521 Clarkson Street

C. Length of stay in Baltimore

60 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

9-22-1871

9. AGE (In years  
last birthday)

78

10. Under 1 Year  
Months Days Hours Min.

5 26

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY  
Own Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Christian Hohenberger

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
No None

16. SOCIAL  
SECURITY NO.  
None

17. INFORMANT ADDRESS  
Mr. Henry Krause-1904 W. Lexington St.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

3 days

ANTECEDENT CAUSES

General and cerebral arterio  
sclerosis

(B)

DUE TO

?

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/16/50, 19 p. to 3/18/, 1950, that I last saw the  
deceased alive on 3/18/, 1950, and that death occurred at 3.10 m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Weiler

M. D.

23B. ADDRESS

1226 Hanover Street,

23C. DATE SIGNED

3/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

3-21-50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cemetery

24D. LOCATION (City, town, or county)

Annapolis Blv. Balto: Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Harry Weiler

25. FUNERAL DIRECTOR

George J. Ruth, Inc. - 1735 Harford Avenue

ADDRESS

MAR 21 1950

VS 150

83a



CERTIFICATE OF DEATH

1914

1914

1914

1914

1914

1914

1914

1914

1914



PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

R-510

50 2579

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2579

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Kate P Rumpf

2. DATE  
OF  
DEATH

March 19 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

2806 Halcyon Ave

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

00

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

8-06

D. STREET ADDRESS (If rural, give location)

1740 N Bond St

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widow

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
at home housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

8. DATE OF BIRTH

Dec 26 1872

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Andrew Lukas

14. MOTHER'S MAIDEN NAME

Theresa M E von Spiess

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Joseph Cilento 2806 Halcyon Ave

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Nephritis

DUE TO

(C)

Anteriosclerotic Cardio-vascular Disease

Cholecystitis

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 10, 1950, to Mar 19, 1950, that I last saw the deceased alive on Mar 18, 1950, and that death occurred at 3:00 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. M. Zimmerman

M. D.

23B. ADDRESS

2058 Sanford Pl.

23C. DATE SIGNED

20 Mar. 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Mar 23/50

24C. NAME OF CEMETERY OR CREMATORY

Balds Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

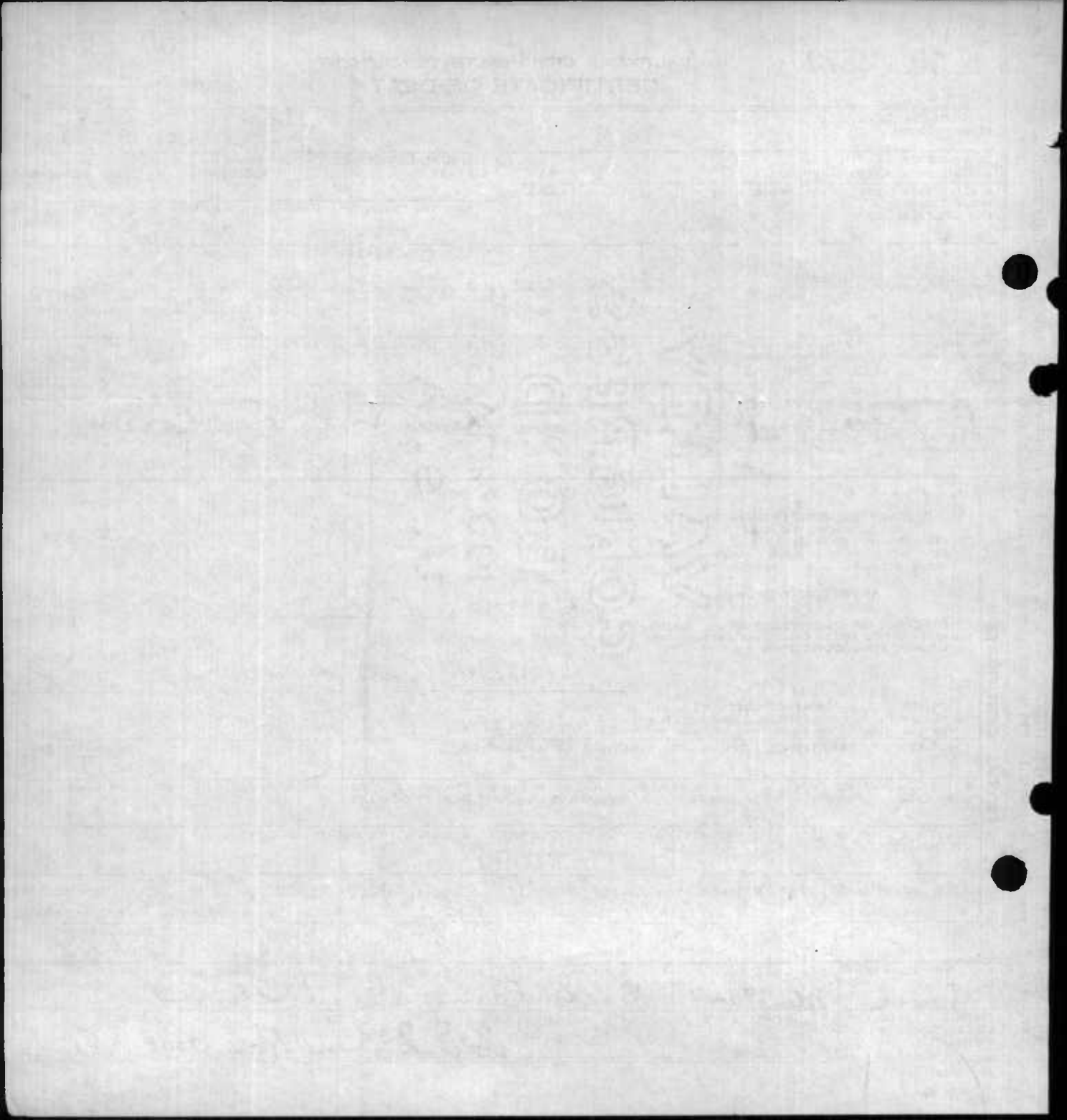
Ellen L. Linn Home 2008 Orleans

ADDRESS

VS 150

131 B







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

P-620  
50 2580

CROSS  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2580

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Christina Cross

2. DATE  
OF  
DEATH

Mar 18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 108 N Steeple

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

MD

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

60

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Bald 6-01

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

108 N Steeple St

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

Feb 7 1876

9. AGE (In years last birthday)

74

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Heenan Wagner

14. MOTHER'S MAIDEN NAME

Laupman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miss Julia Cross 108 N Steeple

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac-Vascular Hypertensive Disease 6 years

DUE TO

(C) Arteriosclerosis

6 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes

6 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 1944, to March 18, 1950, that I last saw the deceased alive on March 17, 1950, and that death occurred at 1 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Michael J. Dausch

M. D.

23B. ADDRESS

4636 Belvoir Road

23C. DATE SIGNED

3-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Mar 21/50

24C. NAME OF CEMETERY OR CREMATORY

Trinity Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

ADDRESS

Edith Funeral Home 2004 Calver







50 2581

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2581

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES LEWIS SHELTON

2. DATE  
OF  
DEATH

3-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2228 CEALEY ST.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1949, to Mar 1950, that I last saw the deceased alive on Mar 16, 1950, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

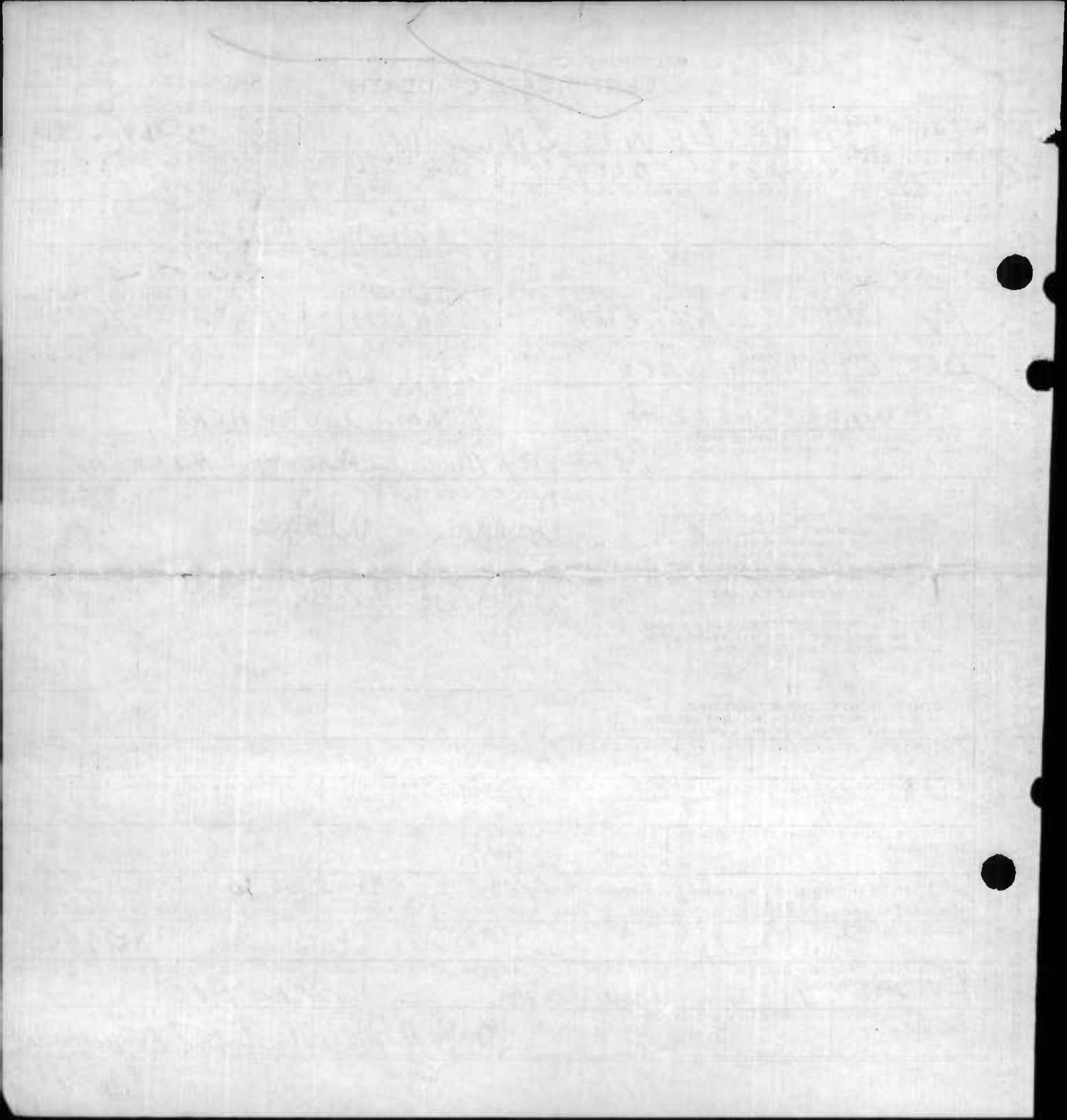
15610

937 St.

PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MEDICAL CERTIFICATION







50 2582

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2582

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Hubert (Herbert) Wm Jones

2. DATE  
OF  
DEATH

3/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

8339 N. Kenwood Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

B. COUNTY

before admission)

5. FULL NAME OF

(If not in hospital or institution, give street address or

HOSPITAL OR  
INSTITUTION

60

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

8339 N. Kenwood Ave

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

25 yrs.

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 12/09

9. AGE (In years,  
last birthday)

40

10 Under 1 Year  
Months: Days:

9 8

11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Sea Food (r)

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Merle Jones

14. MOTHER'S MAIDEN NAME

Bethia Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

218-01-2083

17. INFORMANT

Mrs. Dorothy A. Jones

ADDRESS 833

N. Kenwood

18. 002 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Tuberculous Pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Pulmonary Tuberculosis

5 years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1948, to March 20, 1950, that I last saw the deceased alive on March 19, 1950, and that death occurred at 4:20 AM, from the causes and on the date stated above.

23A. SIGNATURE

John H. Hirschfeld

M. D.

23B. ADDRESS

6919 Harbord Rd

23C. DATE SIGNED

3/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/22/50

24C. NAME OF CEMETERY OR CREMATORY

Cathlamet

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Calvin H. Hirschfeld

ADDRESS 2024

Orleans

VS 150

278 60

130

MEDICAL CERTIFICATION

correct age is especially important. Every item of information should be carefully supplied. The



WALTER M.  
CONGARE

BOND

106241110

106241110



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas J. Getzendanner

2. DATE  
OF  
DEATH

3/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

5401 Windsor Mill Road

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5401 Windsor Mill Rd

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 13, 1887

9. AGE (In years-

last birthday)

62

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Emerson Drug Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas J. Getzendanner

14. MOTHER'S MAIDEN NAME

Mary Ann Chambers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Rose M. Getzendanner 5401 Windsor Mill Rd

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(A)

DUE TO

(B)

DUE TO

(C)

4 days

Cerebral Haemorrhage

Generalized arteriosclerosis, arterio scler-  
otic type heart disease with hypertension  
and congestive failure.

Chronic myocardial disease with  
hypertrophy and degeneration.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 19, 1945 to March 18, 1950 that I last saw the  
deceased alive on March 7, 1950, and that death occurred at 9 P. M., from the causes and on the date stated above.

23A. SIGNATURE

W. Michel

M. D.

23B. ADDRESS

1015 Poplar Grove St. March 20, 1950

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/22/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Pk.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

5/10/50

25. FUNERAL DIRECTOR

ADDRESS

4101 Edmondson Ave.



RECEIVED  
JAN 10 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]

RECEIVED  
JAN 10 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]



655

50 2584

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2584  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FURMAN, HARRY

2. DATE  
OF  
DEATH

3-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
A. STATE B. COUNTY

118 S. Main St Bal Air - Md  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
6200

B. FULL NAME OF HOSPITAL OR INSTITUTION

FRANKLIN SQUARE HOSPITAL

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7/25/1882

9. AGE (In years last birthday)

67

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self-emp PROP.

10B. KIND OF BUSINESS OR INDUSTRY

ICE CREAM STORE

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Furman

14. MOTHER'S MAIDEN NAME

Sarah Ecker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Franklin Square Hospital

18. 163X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) pneumonia & atelectasis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

3-17-50

19B. MAJOR FINDINGS OF OPERATION

CONSOLIDATED MASS, LEFT UPPER LOBE

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-16, 1950 to 3-19, 1950 that I last saw the deceased alive on 3-19, 1950, and that death occurred at 11.05 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Dean B. Camp

23B. ADDRESS

Franklin Sq. Hospital

23C. DATE SIGNED

3-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-22-50

24C. NAME OF CEMETERY OR CREMATORY

Krider Cemetery

24D. LOCATION (City, town, or county) (State)

Wheaton Md

DATE RECEIVED BY LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

Wheaton Md

25. FUNERAL DIRECTOR

Joseph B. Foster Bal Air, Md

ADDRESS

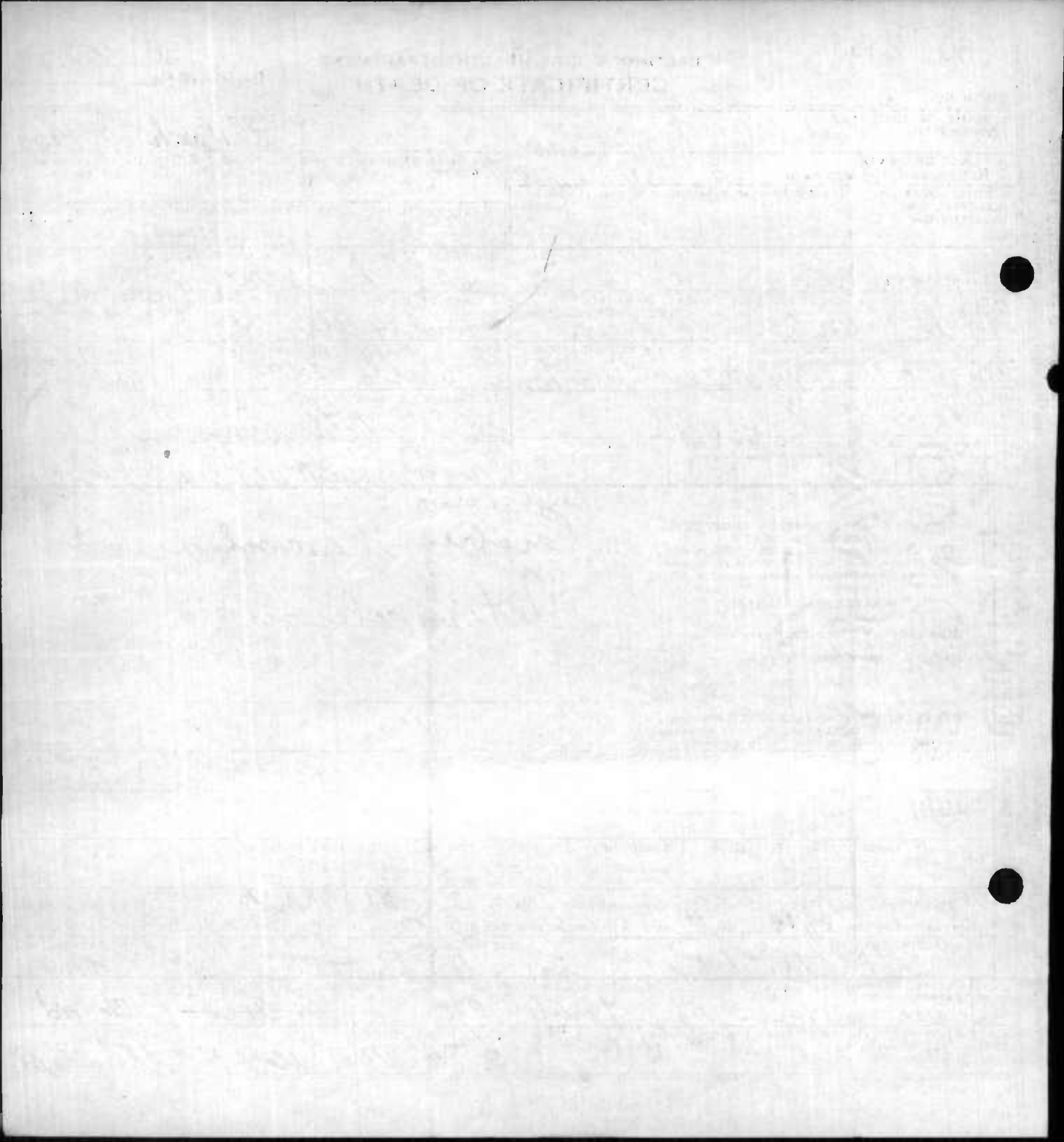


Squamous cell carcinoma. Letter in document file. 50-2584  
4/12/50.



83a







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 159X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 3-14, 1950, to 3-19, 1950, that I last saw the  
deceased alive on 3-18, 1950, and that death occurred at 8:30 Am., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



STANDARD 5000 11/20



5-246

50 2587

# SWISLER

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

50 2587

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Edward N. Swisler*2. DATE  
OF  
DEATH*3/19/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *308 Echdale Ave.*B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

*Life*Yrs.  
Mos.  
Days

5. SEX

*M.*

6. COLOR OR RACE

*N.*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*M.*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired*

10B. KIND OF BUSINESS OR INDUSTRY

*Collector*

8. DATE OF BIRTH

*7/20/1865*

9. AGE (In years last birthday)

*84*If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

*Baltimore*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Nicholas Swisler*

14. MOTHER'S MAIDEN NAME

*Christina Kries*15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs E. N. Swisler*18. *450.0*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*General arteriosclerosis.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

*Acute upper respiratory infection 2 weeks.*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 5*, 19*50*, to *Mar. 19*, 19*50*, that I last saw the deceased alive on *March 19*, 19*50*, and that death occurred at *7:45 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Wm. J. Schmitz*

23B. ADDRESS

*701 N. Kenwood Ave.*

23C. DATE SIGNED

*3/20/50*24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

*3/22/50*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer*

24D. LOCATION (City, town, or county)

*Belair Road*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR*MAR 21 1950*

REGISTRAR'S SIGNATURE

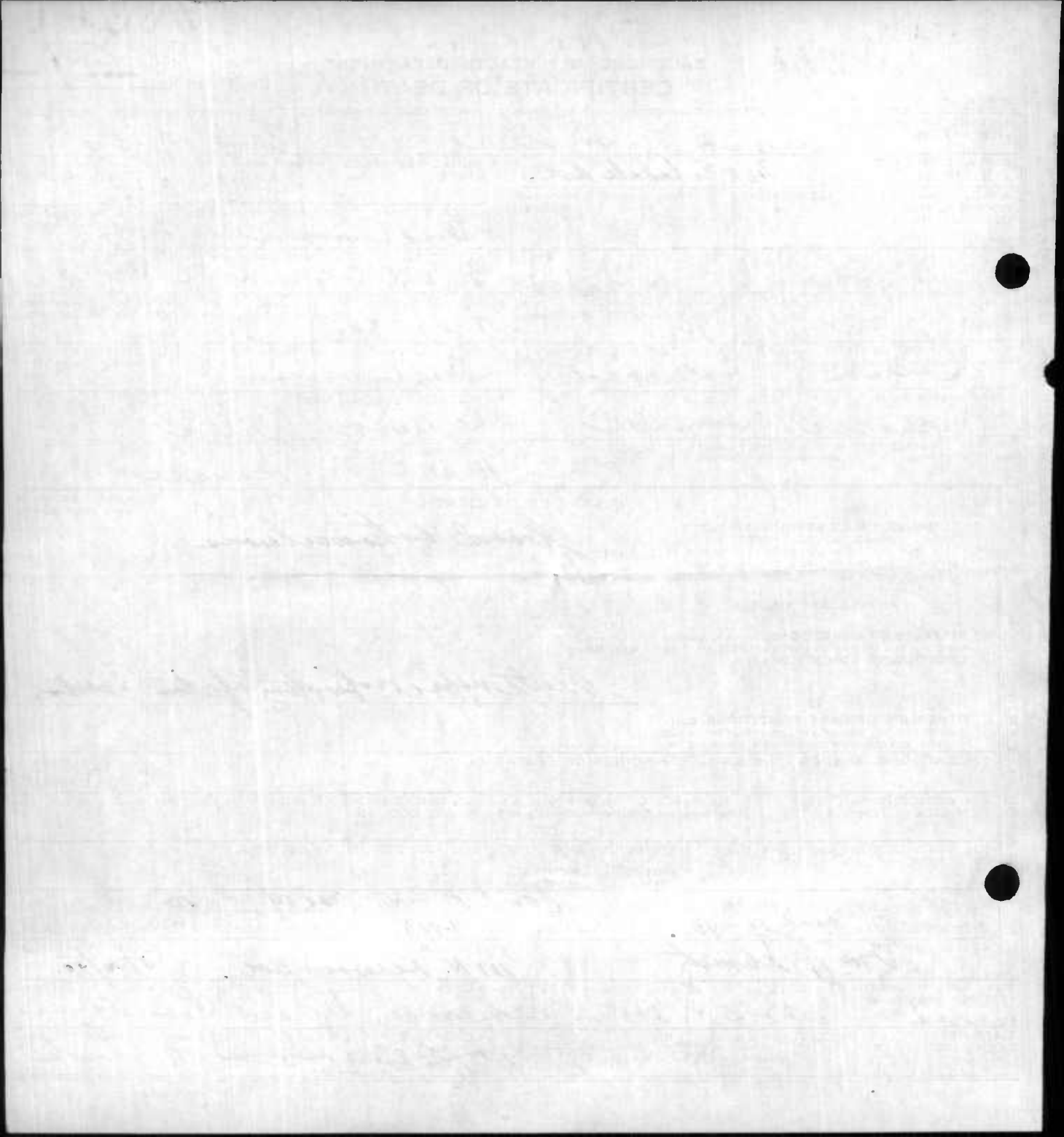
*Wm. J. Schmitz*

25. FUNERAL DIRECTOR

*Wm. J. Schmitz 1318 Light*

97







N-4 25-50 2588

50 2588

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>STANLEY B. WILSON</b>		2. DATE OF DEATH <b>March 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1119 Park Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>11-02</b>	
D. STREET ADDRESS (If rural, give location) <b>1119 Park Ave.</b>		E. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 26, 1880</b>
9. AGE (In years last birthday) <b>70</b>		10. Under 1 Year Months _____ Days _____	11. Under 24 Hours Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Westley Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Phibia ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mrs. Mable Wilson</b>		ADDRESS <b>1119 Park Ave.</b>	

18. <b>422-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Myocarditis</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Arteriosclerosis</b> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <b>Senility</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify, that I attended the deceased from <b>Jan 2</b> , 19 <b>50</b> , to <b>Mar 18</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Mar 13</b> , 19 <b>50</b> , and that death occurred at <b>8 A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Harry Wosselman</b>		23B. ADDRESS <b>1501 Guntaw Ave</b>		23C. DATE SIGNED <b>Mar 20, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-22-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>(Mrs) Frances A. Hemsley</b>		ADDRESS <b>578 W. Biddle St.</b>	

DATE RECEIVED BY LOCAL REGISTRAR **MAR 21 1950** REGISTRAR'S SIGNATURE **Wm. J. H. Hemsley** VS 150 **52086** **937**

If primary informant is physician, please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







MS-131468

50 2589

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2589

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Leo Boyd, Jr.

2. DATE  
OF  
DEATH

2-28-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
location)

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

City Jail

Length of stay in Baltimore

12 yrs. or 12 wks

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan. 8, 1925

9. AGE (In years,  
last birthday)

25

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Leo Boyd

14. MOTHER'S MAIDEN NAME

Madiline Winston

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records--4940 Eastern Ave.

18. DOZ X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELAT-  
E TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30-1949 to 2-28-1950, that I last saw the  
deceased alive on 2-28-1950, and that death occurred at 4:55A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

B.C.H.--4940 Eastern Ave.

3-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Mrs. R. W. Williams Schenck St



This Buckle held at B.E.H. Morge  
for V. A. claimed 3/20/50  
J0013



The attending physician or other qualified person should write the cause of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH:

50 2590  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARGARET J. MULLER

2. DATE  
OF  
DEATH

Mar. 19, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1601 E. 32nd St.

Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 6, 1892

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry T. Jackson

14. MOTHER'S MAIDEN NAME

Margaret Conroy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. E. Lester Muller 1601 E. 32nd St.

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

MYOCARDIAL DEGENERATION

16 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

ARTERIAL HYPERTENSION

8 yrs +

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

5 yrs +

CEREBRAL ARTERIOSCLEROSIS

2 yrs +

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/10, 1948, to 3/19, 1950, that I last saw the deceased alive on 3/17, 1950, and that death occurred at 4:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

W. M. Allen

23B. ADDRESS

6331 Belair Road

23C. DATE SIGNED

3/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 21 1950

W. M. Allen

M. J. TICKNER & SONS

Balto., Md.







correct age is especially important. Physicians: please write the causes of death clearly and legibly. The should be carefully supplied.

CERTIFICATE CORRECTED 3-24-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Florence Magdalene McNally

2. DATE  
OF  
DEATH

3-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4201 Falls Road

Length of stay in Baltimore

Unknown

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 14, 1874

9. AGE (In years,

last birthday)

75

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Texas, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Tracey

14. MOTHER'S MAIDEN NAME

Elizabeth Gallion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

M. Hill

ADDRESS

Mrs. Bernice Hall 4201 Falls Rd.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident

48 Hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

Years

DUE TO

(C) Generalized arteriosclerosis, hard

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-20-50, 19, to 3-20-50, 19, that I last saw the deceased alive on 3-20, 1950, and that death occurred at 10 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/23/50

Cathedral Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

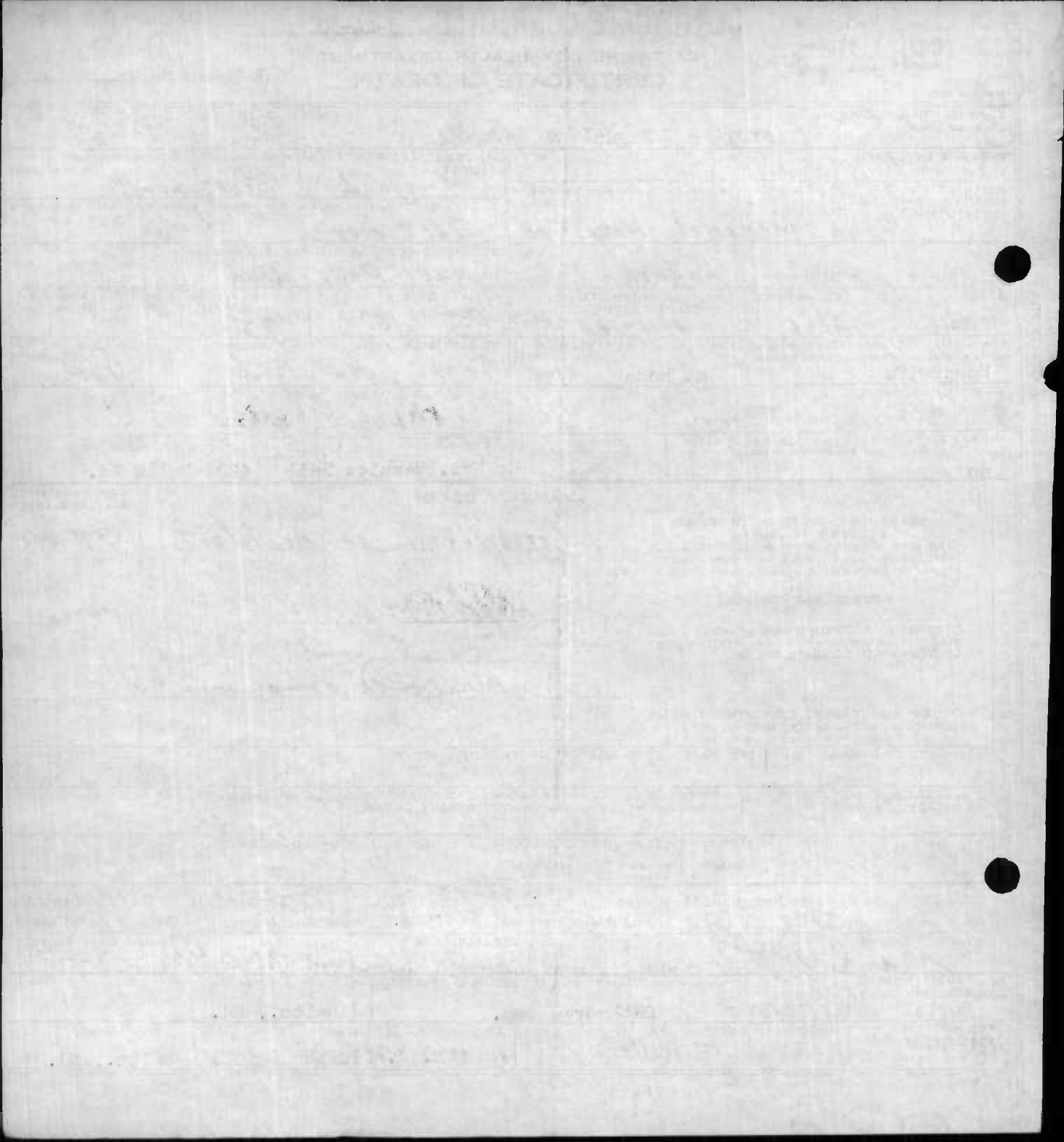
MAR 27 1950

Wm J. Tickner & Sons

25. FUNERAL DIRECTOR

Balto., Md.







- 400  
50 2592BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2592  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MICHAEL W. DOYLE

2. DATE  
OF  
DEATH 3-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1021 S. KENWOOD AVE.

C. Length of stay in Baltimore

?

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORATORY ASST.

10B. KIND OF BUSINESS OR  
INDUSTRY

CITY

13. FATHER'S NAME

MARTIN DOYLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

?

8. DATE OF BIRTH

8-16-1883

9. AGE (in years  
last birthday)

66

11 Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

SUSAN McNAMARA

17. INFORMANT

ADDRESS

WM. L. DOYLE - SAME

18. 443 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage

3 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertensive Cardio-Vascular  
Disease

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/18/50 to 3/20/50, that I last saw the  
deceased alive on 3/20/50, and that death occurred at 11:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 21 1950

KILBY &amp; ZEILER INC. BALTO. MD.

BALTO. MD.



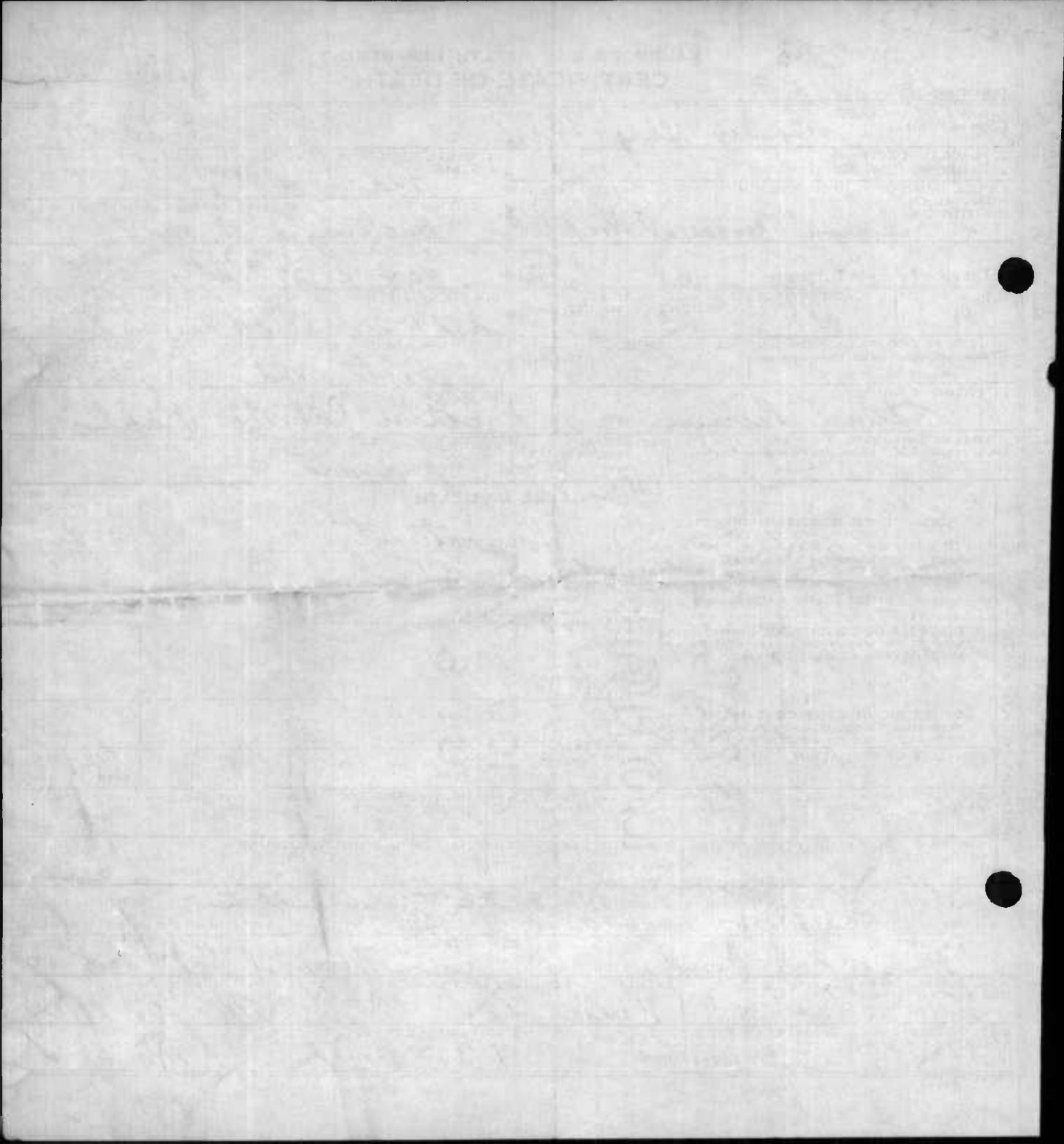
Dr. Karakowski  
1016 S. East Ave.



Contact age is especially important. Physicians: please write the causes of death clearly and legibly.

<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">650</div> <div style="font-size: 1.5em; font-weight: bold; margin-bottom: 5px;">50 2593</div> <div style="font-size: 1.2em; font-weight: bold; margin-bottom: 5px;">PERRINE</div> <div style="font-size: 1.1em; font-weight: bold; margin-bottom: 5px;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.2em; font-weight: bold; margin-bottom: 5px;">CERTIFICATE OF DEATH</div>		<div style="font-size: 1.5em; font-weight: bold; margin-bottom: 5px;">50 2593</div> <div style="font-size: 1.1em; font-weight: bold; margin-bottom: 5px;">Registered No.</div>	
1. NAME OF DECEASED (Type or Print) <i>Baby Ray Perrine</i>		2. DATE OF DEATH <i>3-20-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>16-03</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 18, md</i>	
Length of stay in Baltimore <i>24</i> <small>Mr. Moore Days</small>		D. STREET ADDRESS (If rural, give location) <i>404 E. 27th St.</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i>	8. DATE OF BIRTH <i>2-24-50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <i>24 days</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, md</i>	
13. FATHER'S NAME <i>Edwin Perrine</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>parents</i>		ADDRESS	
18. <i>776 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Prematurity</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>24 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>-</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2-24-50</i> , 19 <i>50</i> , to <i>3-20-50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-20-50</i> , 19 <i>50</i> , and that death occurred at <i>1:35a.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Donald B. Bond</i>		23B. ADDRESS <i>Union Memorial Hosp.</i>	23C. DATE SIGNED <i>3-20-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>3-21-50 Removal</i>	24B. DATE <i>3-21-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>White Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Garrett Co. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 21 1950</i>	REGISTRAR'S SIGNATURE <i>Herbert Lighten</i>	25. FUNERAL DIRECTOR <i>Herbert Lighten</i>	
		ADDRESS <i>Oakland md.</i>	

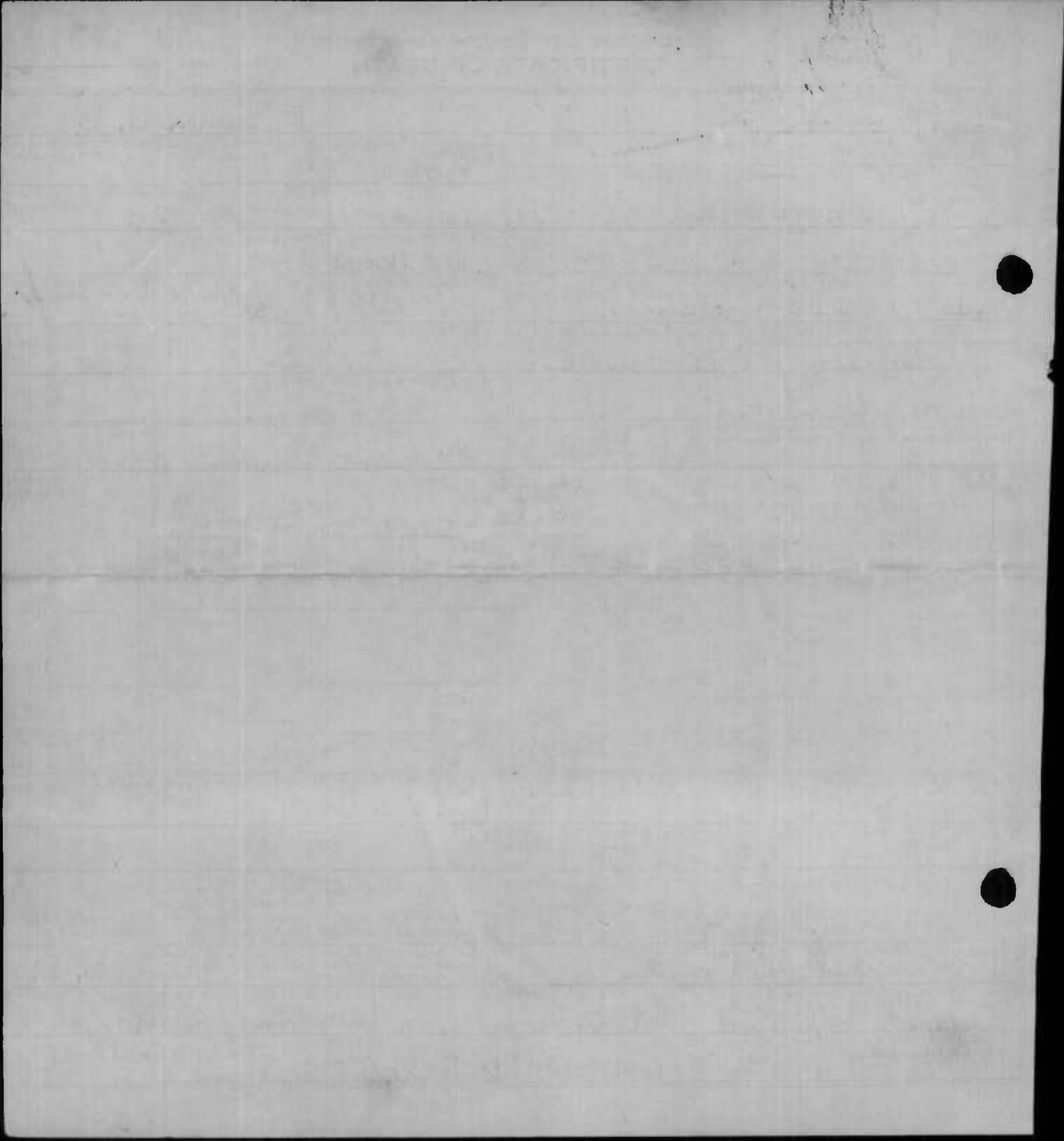






<div style="display: flex; justify-content: space-between;"> <span>12-620 50 2594</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>50 2594</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		Registered No. _____	
BIRTH NO. _____			
1. NAME OF DECEASED (Type or Print) <b>CHARLES GROSS</b>		2. DATE OF DEATH <b>March 19, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		C. CITY OR TOWN (if outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
Length of stay in Baltimore <b>50 yrs.</b>		D. STREET ADDRESS (if rural, give location) <b>1008 Vincent Street</b>	
6. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>1887</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Job Work</b>	9. AGE (in years last birthday) <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Samuel Gross</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Andrew Mullen</b>		ADDRESS <b>512 Mount St.</b>	
18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anterior-Septal Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH _____	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		(B) _____	
19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. CHIEF MEDICAL EXAMINER _____	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <b>Carl H. Boyer</b>		23B. CHIEF MEDICAL EXAMINER _____ ASSISTANT MEDICAL EXAMINER _____ MEDICAL INVESTIGATOR _____	
23C. DATE SIGNED <b>March 20, 1950</b>		24. LOCATION (City, town, or county) (State) <b>West Pat. Balto. Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/23/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. NAME OF FUNERAL HOME <b>Metropolitan Funeral Home Inc.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 21 1950</b>		REGISTRAR'S SIGNATURE <b>W. H. Adams</b>	
FUNERAL DIRECTOR <b>Metropolitan Funeral Home Inc.</b>		ADDRESS <b>927 Mount St.</b>	







620  
50 2595

50 2595

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Lethia Harris*

2. DATE  
OF  
DEATH

*March 20, 1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*1127 Lexington St*

Yrs.  
Mos.  
Days

Length of stay in Baltimore

*1929*

5. SEX

*F.*

6. COLOR OR RACE

*C.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widow*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Md.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

*5-01*

D. STREET ADDRESS (If rural, give location)

*1127 E. Lexington St.*

8. DATE OF BIRTH

*June 7, 1893*

9. AGE (In years last birthday)

*56*

10. Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Domestic*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*S.C.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Edmond Drakeford*

14. MOTHER'S MAIDEN NAME

*Lucinda Drakeford*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Andrew Harris 1127 E. Lexington St.*

18. *334X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Cerebral arteriosclerosis*

*2 wks*

ANTECEDENT CAUSES

(B) DUE TO

*Hypertension*

*?*

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *3-2*, 19*50*, to *3-20*, 19*50*, that I last saw the deceased alive on *3-20*, 19*50*, and that death occurred at *1:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Wm. L. Roy Perry*

23B. ADDRESS

*1420 E. Chase*

23C. DATE SIGNED

*3-20-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 23, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Mt Calvary Cem*

24D. LOCATION (City, town, or county) (State)

*A.A. County Md*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 21 1950*

REGISTRAR'S SIGNATURE

*William L. Roy Perry*

25. FUNERAL DIRECTOR

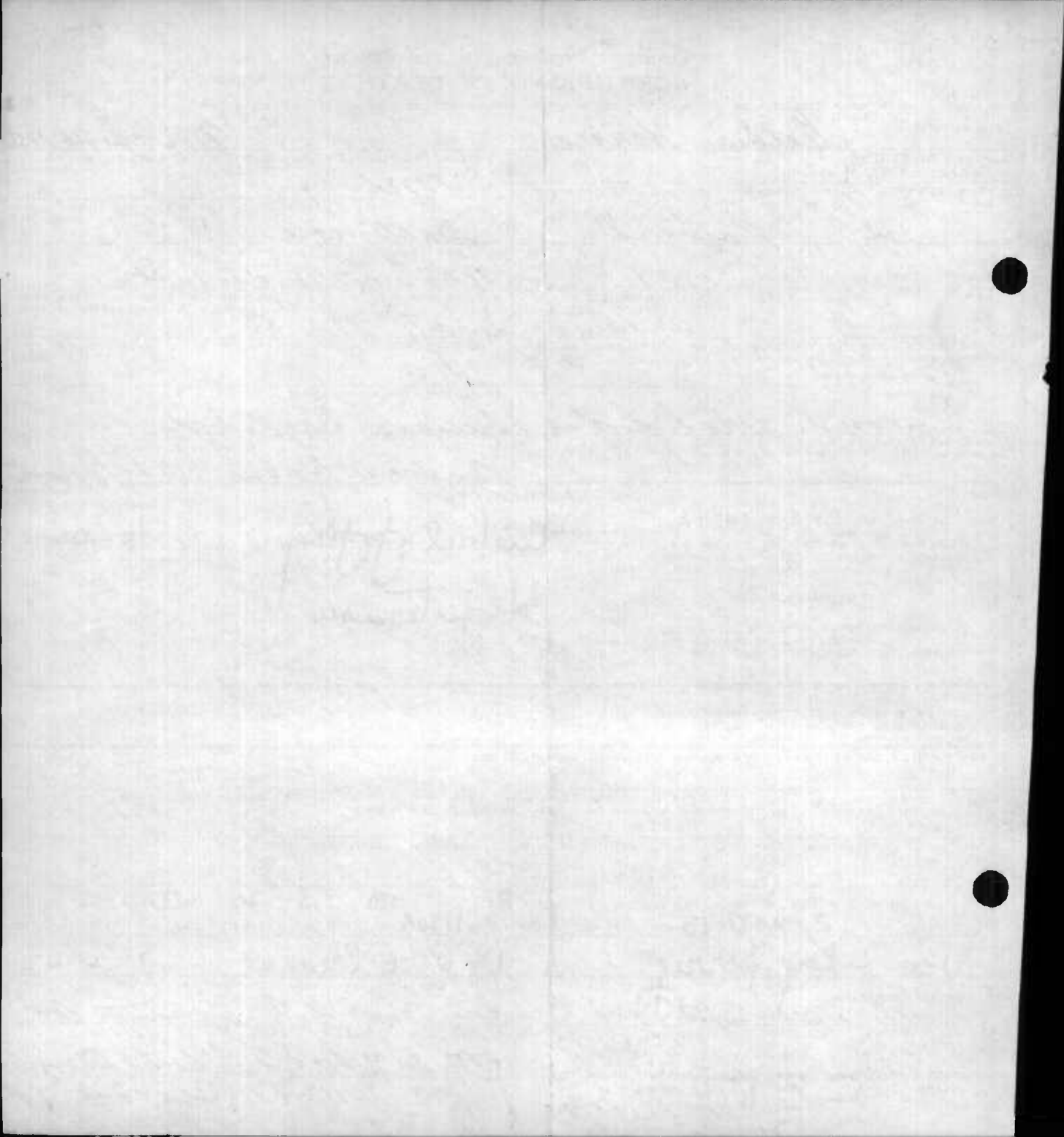
*Mr. Robert A. Elliott & Daugherty*

ADDRESS

*1129 N. Caroline St*

*83a*







50 2596

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2596  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES M. SKIPPER</b>		2. DATE OF DEATH <b>March 20, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
Length of stay in Baltimore <b>20 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>1112 Thompson Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>March 30, 1904</b>
		9. AGE (in years last birthday) <b>45</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Mace Produce Co (W)</b>		11. BIRTHPLACE (State or foreign country) <b>Pa</b>	
13. FATHER'S NAME <b>Willie Skipper</b>		12. CITIZEN OF WHAT COUNTRY? <b>France</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-095-197</b>	
		17. INFORMANT <b>Lena Rawlings</b>	
		ADDRESS <b>1112 Thompson</b>	

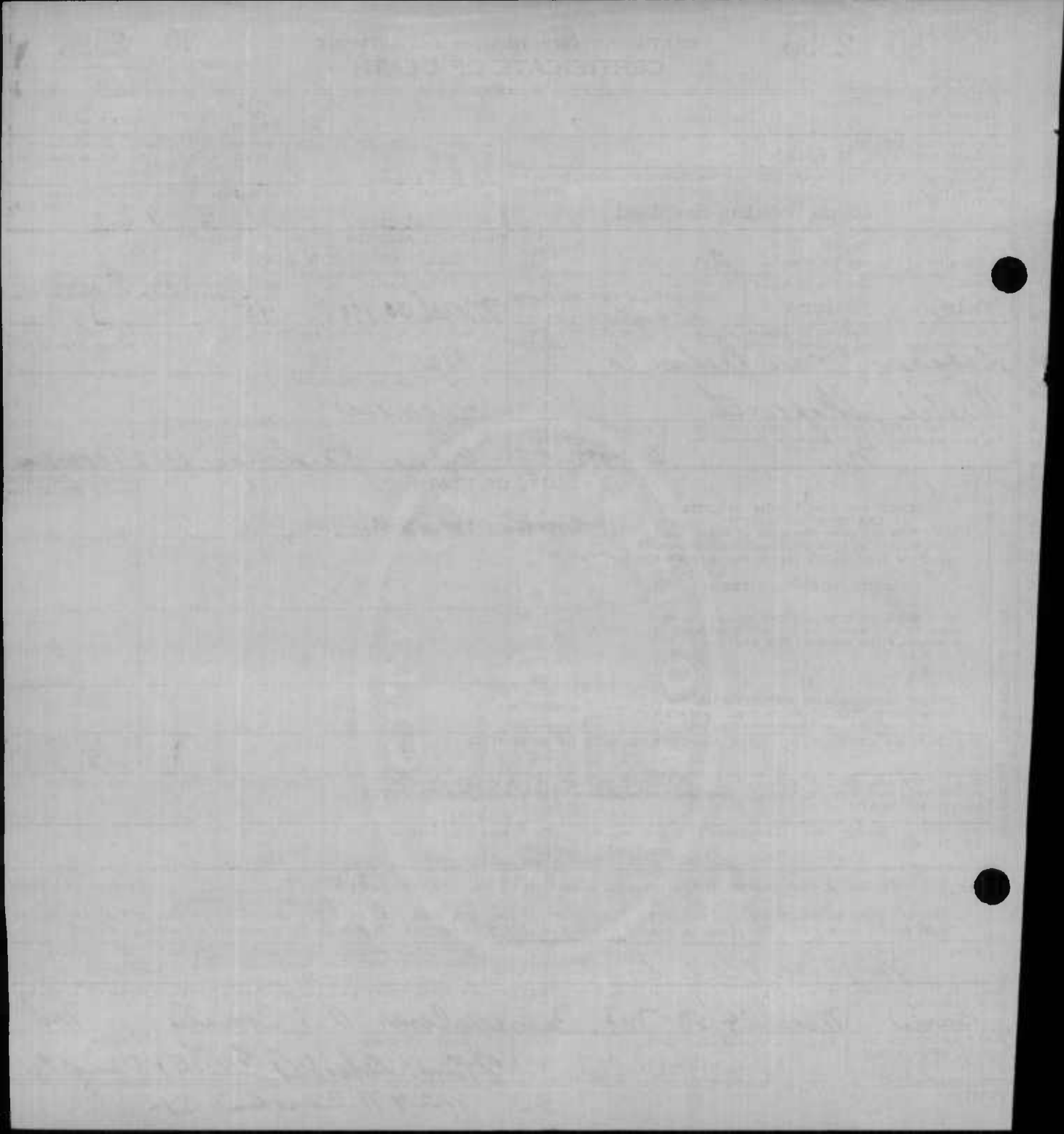
MEDICAL CERTIFICATION

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

2. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>H. A. Mc Clafferty</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>3-20-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>March 24/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>	24D. LOCATION (City, town, or county) <b>A.A. County Md</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>		REGISTRAR'S SIGNATURE <b>H. A. Mc Clafferty</b>		25. FUNERAL DIRECTOR <b>Wm. Robert G. Elliott &amp; Daughter</b>	
				ADDRESS <b>1129 N. Caroline St</b>	







653  
50 2597

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2597  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Richard Garnett*

2. DATE  
OF  
DEATH

*March 18, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: Residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

*124 S. Caroline St*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

*3-01*

D. STREET ADDRESS (If rural, give location)

*124 S. Caroline St.*

5. SEX

*Male*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
*Married*

8. DATE OF BIRTH

*Aug 6, 1907*

9. AGE (In years

last birthday)  
*42*

If Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Laborer - City of Balt - Water Supply Div.*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*W. Va.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Joseph Garnett*

14. MOTHER'S MAIDEN NAME

*unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

*Yes World War # 2*

16. SOCIAL SECURITY NO.

17. INFORMANT

*Lydia Garnett*

ADDRESS

*124 S. Caroline St*

18. *421.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

*3 months*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Aortic decompensation*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *1-20*, 19*50*, to *3-17*, 19*50*, that I last saw the deceased alive on *17 March*, 19*50*, and that death occurred at *1:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*G. C. Surwell*

M. D.

23B. ADDRESS

*181 Airgarden*

23C. DATE SIGNED

*3-20-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Baltimore National Cem*

24D. LOCATION (City, town, or county)

*Md.*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 21 1950*

REGISTRAR'S SIGNATURE

*Washington Williams*

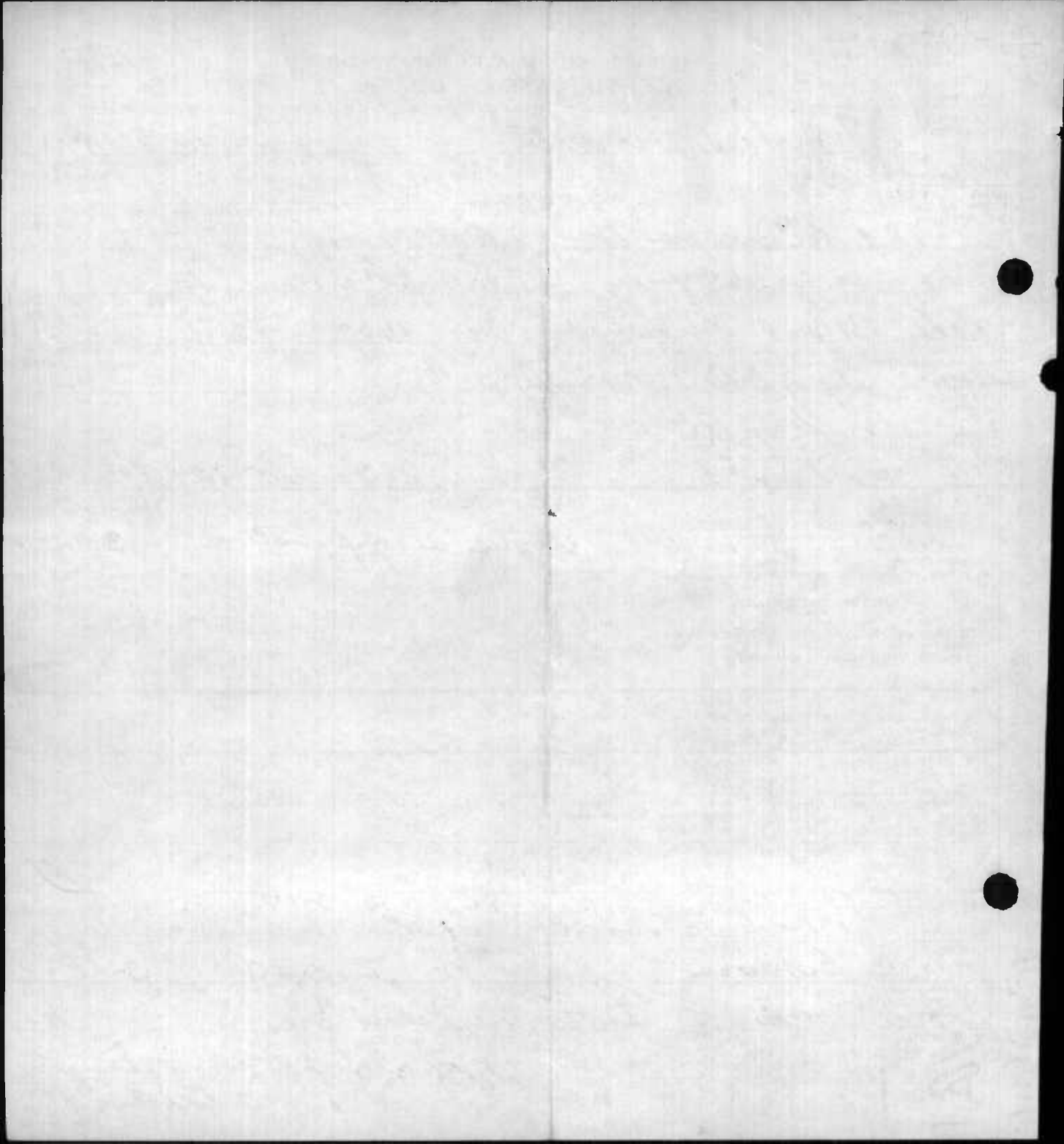
25. FUNERAL DIRECTOR

*Mr. Robert A. Elliott & Daughter*

ADDRESS

*1129 N. Caroline St.*











CERTIFICATE OF DEATH

1911 April 14

1911

1911 April 14



correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2599  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alice A. Reindollar

2. DATE

OF DEATH March 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

none

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

12-02

D. STREET ADDRESS (If rural, give location)

Homewood Apts., Charles & 31st Sts.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

April 12, 1962

9. AGE (In years last birthday)

87

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob T. Reindollar

14. MOTHER'S MAIDEN NAME

Josephine Verney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William Larmour Reindollar-4108 Belle Ave.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage;

DUE TO

2 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis;

DUE TO

? yr.

(C) Senility.

? yr.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from about 1939, to Mar. 20, 1950, that I last saw the deceased alive on Mar. 19, 1950, and that death occurred at 11:04 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Robert R. Skyles

M. D. Medical Arts Building

3 - 21 - 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

burial

3/22/50

Baltimore

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 21 1950

John O. Mitchell & Sons, Inc.

1900 Eutaw Pl.



CERTIFICATE OF DEATH

FILE NO. 100-100000

FILE NO. 100-100000

RECORDED AT 100-100000

FILE NO. 100-100000

FILE NO. 100-100000

FILE NO. 100-100000

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FILE NO. 100-100000

FILE NO. 100-100000

FILE NO. 100-100000



correct and is especially important. Physicians: please write the causes of death clearly and legibly. The

0-630

50 2600

CERTIFICATE CORRECTED

3-24-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 2600

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH A. PRATT

2. DATE  
OF DEATH

MARCH 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION 1708 W. FRANKLIN ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

19-01

D. STREET ADDRESS (If rural, give location)

1708 W. FRANKLIN ST.

Length of stay in Baltimore

40 yrs.

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Aug 5, 1893

9. AGE (In years, last birthday)

56

10. Under 1 Year Months: Days

6 16

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dorchester Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

AARON Cornish

14. MOTHER'S MAIDEN NAME

Sophia Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Pratt

ADDRESS

ALLEN Wilson, 1708 W. FRANKLIN ST.

18. 490X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Congestion

Several Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bilateral Lobar Pneumonia

Several wks.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from February 26, 1950, to March 18, 1950, that I last saw the deceased alive on March 18, 1950, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Richard H. Hunt

M. D.

23B. ADDRESS

1631 W. Franklin St.

23C. DATE SIGNED

3-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

B.

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

Cheltenham

24D. LOCATION (City, town, or county)

Balto Co.

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

Richard H. Hunt

25. FUNERAL DIRECTOR

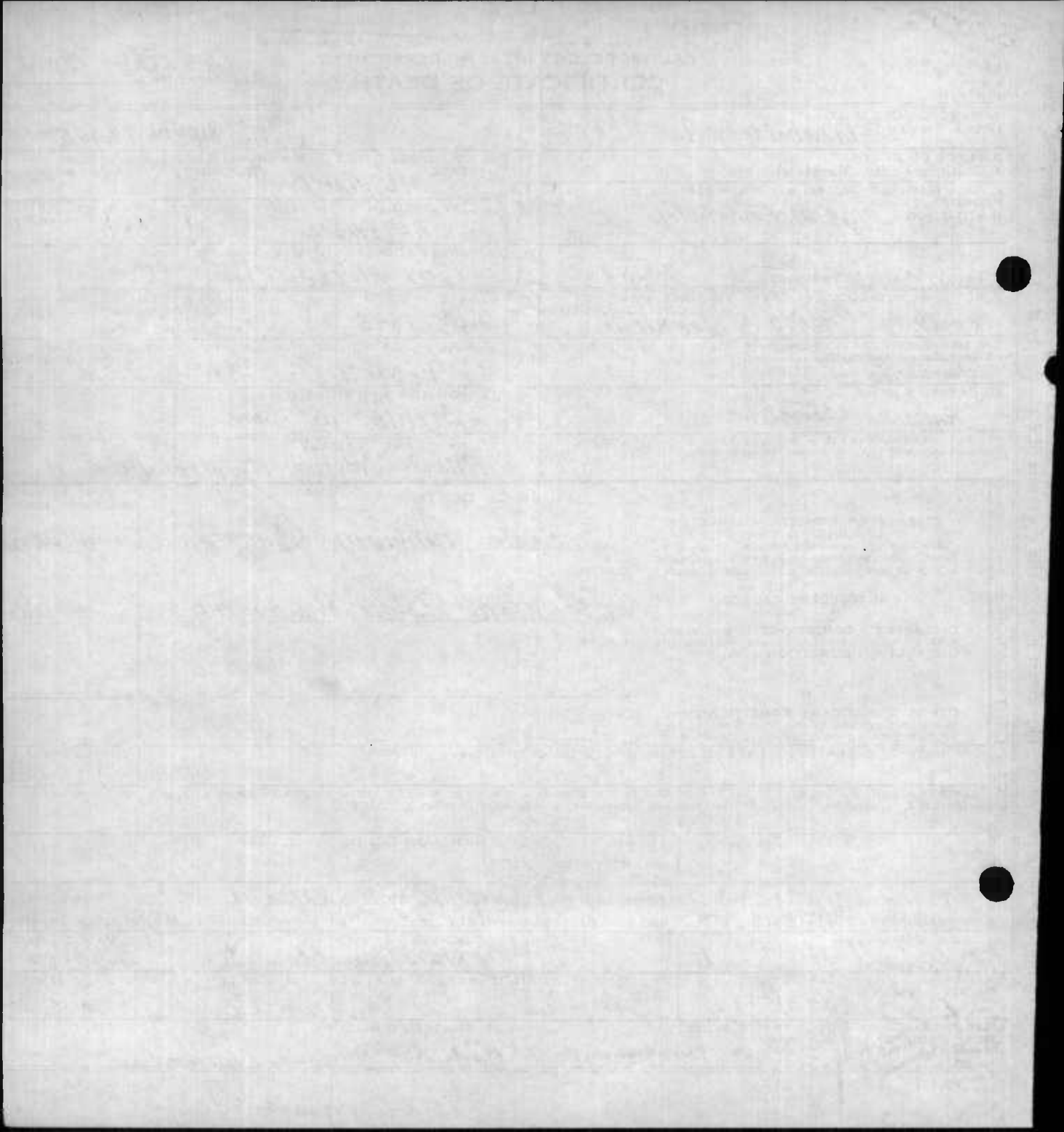
Robert M. Wight

ADDRESS

724 Asquith St

108







0-360  
50 2601

50 2601

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

STANISLAUS PATRO

2. DATE OF DEATH 3-19-50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)

3215 E. FAIRMOUNT AVE.

Length of stay in Baltimore ?  
Yrs. Mos. Days

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

GROCER

10B. KIND OF BUSINESS OR INDUSTRY

SELF

13. FATHER'S NAME

CASIMIR PATRO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

?

17. INFORMANT

JOSEPH S. PATRO

ADDRESS

SAME

18. 332 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

TERMINAL BRONCHO-PNEUMONIA

INTERVAL BETWEEN ONSET AND DEATH

2 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CEREBRAL THROMBOSIS

3/15/50

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

GENERALIZED ARTERIOSCLEROSIS  
FRACTURE OF SKULL WITH RESIDUAL HEMIPLEGIA

??  
JULY 1948

19A. DATE OF OPERATION NONE

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  
Accident

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
3215 E. Fairmount Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
July, 1948

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?  
Collapsed and fell to floor

22. I hereby certify that I attended the deceased from MARCH 15, 1950, to MARCH 19, 1950, that I last saw the deceased alive on MARCH 19, 1950, and that death occurred at 9:45A.m., from the causes and on the date stated above.

23A. SIGNATURE  
J. F. Drunga

23B. ADDRESS  
209 S. Chester St.

23C. DATE SIGNED  
3/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
BURIAL

24B. DATE  
3/22/50

24C. NAME OF CEMETERY OR CREMATORY  
HOLY ROSARY

24D. LOCATION (City, town, or county) (State)  
BALTO. CO. MD.

DATE RECEIVED BY LOCAL REGISTRAR  
MAR 21 1950

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

LEIPER INC. BALTO. MD.

ADDRESS

15661

832

The information on this certificate is to be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



200.5  
15770.002  
①  
15770.002



The information on this certificate should be carefully prepared. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2602  
Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BENNY A. (Benjamin) SULLIVAN		2. DATE OF DEATH March 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland			
B. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01			
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 604 Baker Street			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 20, 1899	9. AGE (In years last birthday) 50 51	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 218-01-7317		17. INFORMANT ADDRESS Erma Sullivan 1351 N. Gilmore St.	
18. E 981 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BULLET WOUND OF BRAIN CAUSE OF DEATH (A) Bullet wound of brain DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 604 Baker Street	
21D. TIME (Month) (Day) (Year) (Hour) March 18, 1950 11:30P.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? firearms	
22. I certify that I took charge of the remains described above, held an _____ Partial autopsy _____ thereon and from _____ Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE E. H. Rogers M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 3-20-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/50		24C. NAME OF CEMETERY OR CREMATORY Balto. National	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. FUNERAL DIRECTOR Geo. G. Kelson 1303 Presstman St		24F. ADDRESS	

VS 151

N-853

98499

166



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY

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PLANT INDUSTRY



Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

EMIL E. MYNAR

2. DATE  
OF  
DEATH

March 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2700 Ashland Ave.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2700 Ashland Avenue

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 11, 1883

9. AGE (In years  
last birthday)

67

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

retired

10B. KIND OF BUSINESS OR  
INDUSTRY

own grocery business

11. BIRTHPLACE (State or foreign country)

(R) Czechoslovakia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joseph Mynar

14. MOTHER'S MAIDEN NAME

Anna Dobihal

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Anna Mynar - wife - 2700 Ashland Ave.

18. 241X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

3 days

10 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 17, 1950, to March 19, 1950, that I last saw the  
deceased alive on March 11, 1950, and that death occurred at 7:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

L. C. Dobihal

23B. ADDRESS

M. D.

4474 Kenwood Ave.

23C. DATE SIGNED

3/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 22, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Schimmels Funeral Home, Inc.

ADDRESS

2601 E. Madison St.

VS 150

15661

93E



CERTIFICATE OF DEATH

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Age at death		6. Sex	
7. Race		8. Marital status	
9. Occupation		10. Signature of declarant	
11. Date of declaration		12. Signature of registrar	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2604  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Matilda A. Matzdorf

2. DATE  
OF  
DEATH

Mar. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2906 Elliott St.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Mar. 16, 1866

9. AGE (In years last birthday)

84

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

house wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Jacob Matzdorf 3503 Glenarm Ave.

18. 500 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute bilateral bronchitis

10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial Insufficiency

6 days

DUE TO

(C) Arterio-sclerosis

?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Nephritis

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from March 10, 1948, to March 18, 1950 that I last saw the deceased alive on 3-18-, 19 50, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

J. A. Brownshas, M. D.

23B. ADDRESS

3037 O'Donnell St.

23C. DATE SIGNED

3-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

Schwartz's

24D. LOCATION (City, town, or county) (State)

O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

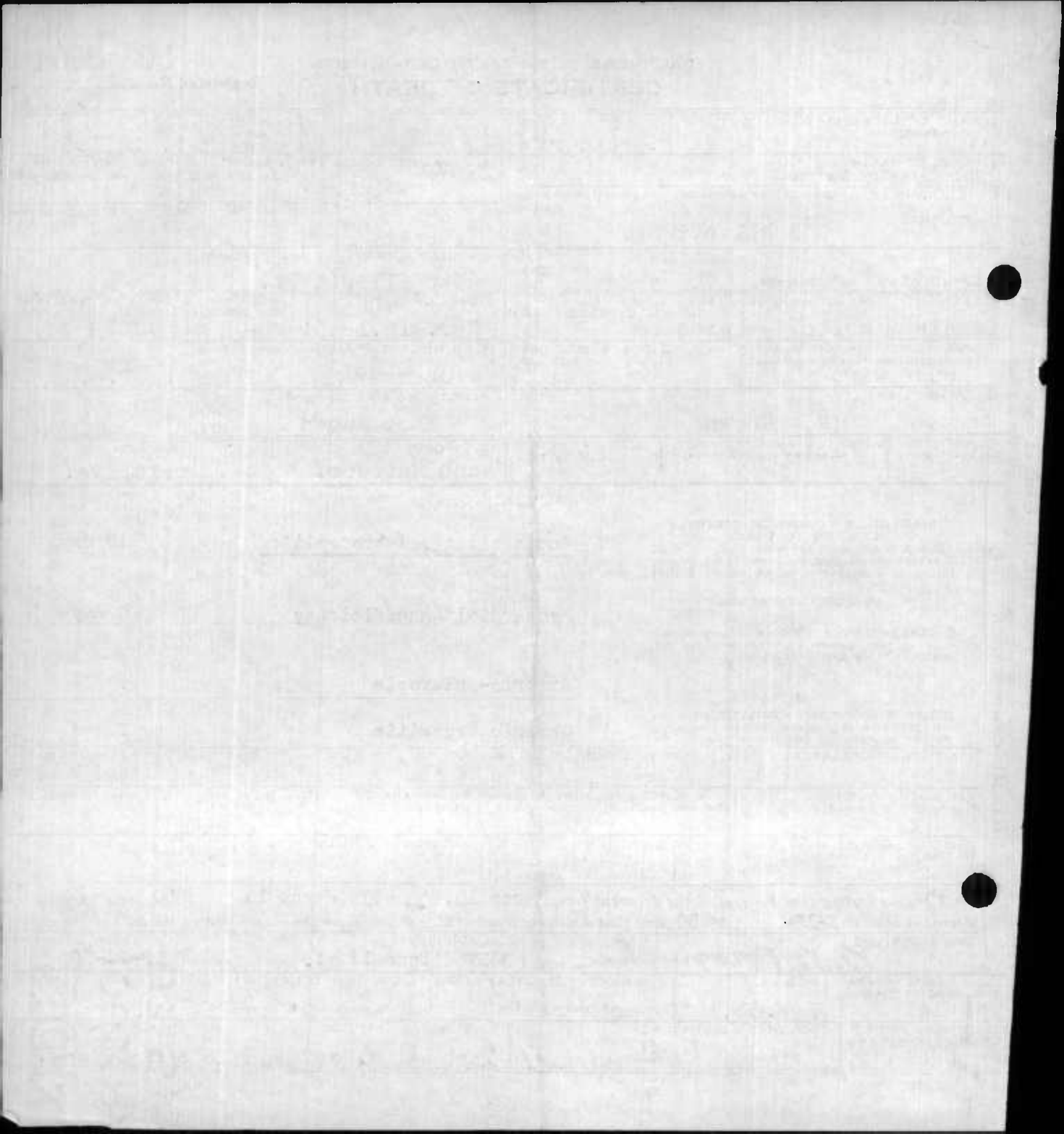
ADDRESS

MAR 21 1950

Matthew J. Hoffman

2460 E. Hoffmann 1639 Broadway.







Medical Certification: Please write the causes of death clearly and legibly.

M-240

50 2605

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2605

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mrs. GERTRUDE O. MICHAEL</b>			2. DATE OF DEATH <b>3/20/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>26-05</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>25 Church Home + Hosp.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. 24</b>		
Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>405 South Cornwall St.</b>		
6. SEX <b>F</b>	7. COLOR OR RACE <b>W</b>	8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	9. DATE OF BIRTH <b>Oct. 14, 1894</b>	10. AGE (In years last birthday) <b>55</b>	11. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			12. Under 24 Hours Hours: Min.		
10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Joseph Holston</b>			14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
14. MOTHER'S MAIDEN NAME <b>Lena Rubert</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>LOUIS MICHELBERGER</b> ADDRESS <b>Sand</b>		

18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> DUE TO <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH <b>Pulmonary Edema</b> <b>Hypertensive Cardiovascular Disease</b>	INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
--	--	--	---

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
2. I hereby certify that I attended the deceased from <b>3/17</b> <b>1950</b> , to <b>3/20</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3/20</b> , 19 <b>50</b> , and that death occurred at <b>2 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Robert E. Enzor</b> M. D.		23B. ADDRESS <b>Church Home + Hosp.</b>		23C. DATE SIGNED <b>3/20/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar. 23, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Ave.</b>		25. FUNERAL DIRECTOR <b>Clarence F. Hoffmann</b> ADDRESS <b>1639 Broadway.</b>			

AR 21 1950



032

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1. NAME OF LAND ACQUISITION PROJECT	
2. LOCATION OF PROJECT	
3. DATE OF ACQUISITION	
4. TYPE OF ACQUISITION	
5. AMOUNT OF ACQUISITION	
6. SOURCE OF FUNDS	
7. PURPOSE OF ACQUISITION	
8. STATUS OF ACQUISITION	
9. COMMENTS	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2606

1. NAME OF DECEASED (Type or Print) <i>Jennie Stafnelli</i>		2. DATE OF DEATH <i>3/20/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>133 So. Poppleton St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Length of stay in Baltimore <i>35 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>133 So. Poppleton St.</i>	
SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 24-1892</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cotton garment maker</i>		10B. BUSINESS OR INDUSTRY <i>md. Sports wear</i>	9. AGE (In years; last birthday) <i>57</i>
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michele Stafnelli</i>		14. MOTHER'S MAIDEN NAME <i>Rochena Guello</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Marie Tompo</i>		18. ADDRESS <i>3800 Chew Ave Phila Pa.</i>	

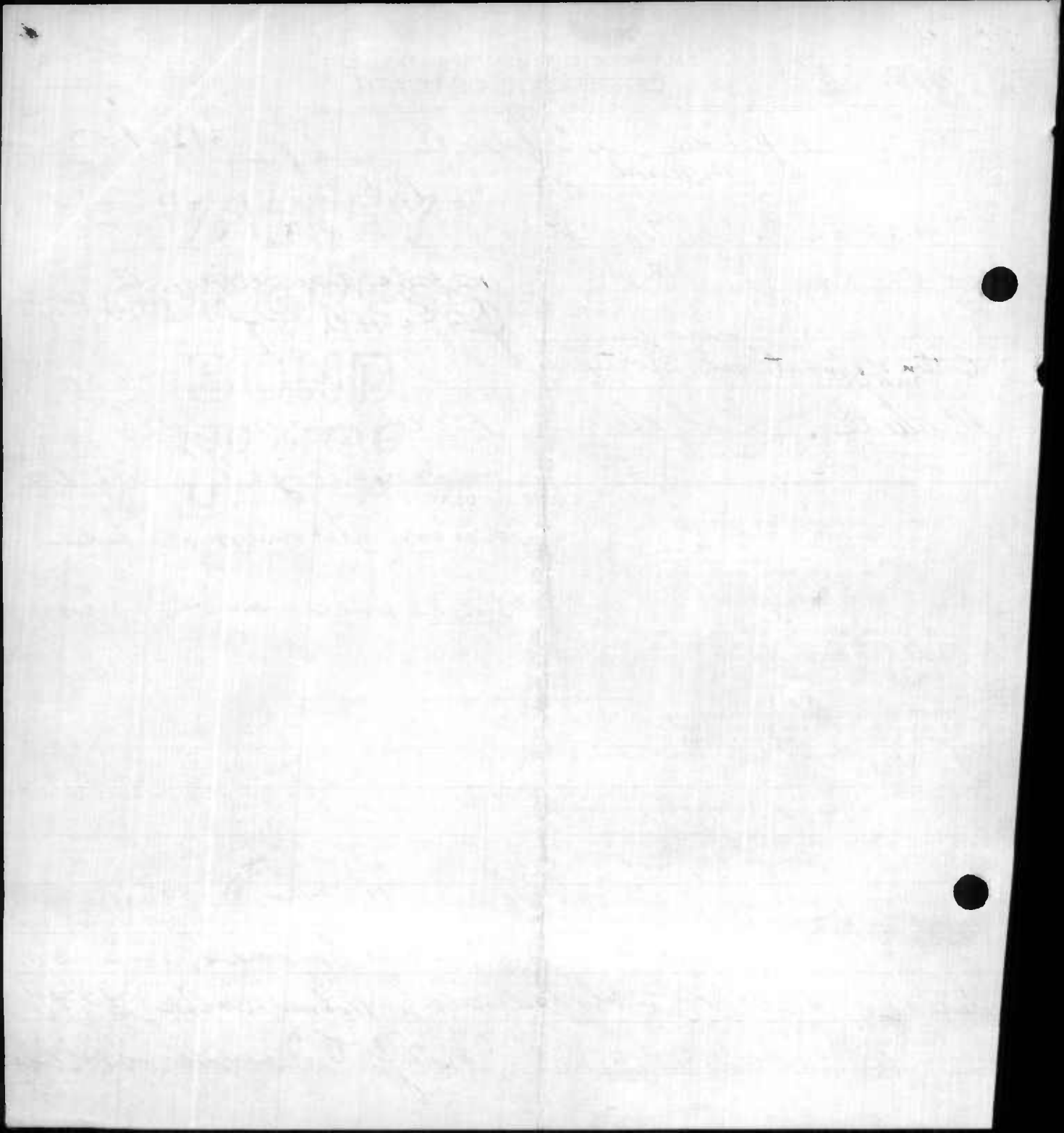
18. <i>420.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Bronchio pneumonia</i> DUE TO		<i>1 wk.</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

I hereby certify that I attended the deceased from *March 13, 1950*, to *March 20, 1950*, that I last saw the deceased alive on *March 19, 1950*, and that death occurred at *7 A m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Albert Scagnitti</i> M. D.		23B. ADDRESS <i>1724 W Lombard St</i>		23C. DATE SIGNED <i>3-21-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) <i>Belmond &amp; Ortho, Phila</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 21 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
24G. FUNERAL DIRECTOR <i>John J. Brown &amp; Son</i>		24H. ADDRESS <i>942 St</i>		24I. 49606	







MS-136520  
50 2607BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2607

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eddie Gibson

2. DATE  
OF  
DEATH

3-16-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1513 Jefferson St.

Length of stay in Baltimore

25 yrs.

Yrs.  
Mos.  
DaysSEX  
Male6. COLOR OR RACE  
Negro7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Single8. DATE OF BIRTH  
Jan. 1, 19039. AGE (In years  
last birthday)  
4710 Under 1 Year  
Months: Days  
11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY11. BIRTHPLACE (State or foreign country)  
South Carolina12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Gib. Gibson

14. MOTHER'S MAIDEN NAME

Nellie Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records--B.C.H.--4940 Eastern Ave.

18. 521.X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary Abscess, Multiple both  
lungs, due to staphylococcus aureus  
aureus

over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 3-12-1950 to 3-16-1950, that I last saw the  
deceased alive on 3-16-1950, and that death occurred at 8:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Rogers

M. D.

23B. ADDRESS

B.C.H.--4940 Eastern Ave.

23C. DATE SIGNED

3-15-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/21/50

24C. NAME OF CEMETERY OR CREMATORY

Zurkurn Burn

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston W. Williams

25. FUNERAL DIRECTOR

Charles W. Per

ADDRESS

MAR 21 1950

VS 150

114D



Letter in document file 50-2607 - 3/31/50.



-165

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2608  
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland  
(b) Street address. 1153 HAUBERT ST.  
(c) Hospital or institution: 00  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County  
(c) City or town BALTIMORE 24-01  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. 1153 HAUBERT ST.  
(If rural give location)  
(e) Citizen of foreign country? YES (Yes or No)  
If yes, name country IRELAND.

3 (a) FULL NAME

Mary O'Brien

3 (b) If veteran, name was 3 (c) Social Security Account No. NONE

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife MARTIN  
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace IRELAND  
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name UNKNOWN

13. Birthplace

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace

16 (a) Informant MARTIN O'BRIAN

(b) Address 1153 HAUBERT ST.

17 (a) BURIAL (b) Date thereof 3/22/50  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral  
Location Balt. Md.

18 (a) Funeral director Chas. F. Will

(b) Address 1501 E. Fort Ave

19 MAR 21 1950 (Date rec'd by registrar) William Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 19 50, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17, 19 50, to March 18, 19 50, and that I last saw her alive on March 17 19 50.

Immediate cause of death Bronchopneumonia Duration 3 days.

Due to Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 0

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Monte J. Brown M.D.

Address 516 Cathedral St. Date signed 3/21/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2609  
Registered No.

50 2609  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SALLIE HOOVER UREY</b>			2. DATE OF DEATH <b>3-19-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>West Baltimore General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3908 Belle Ave.</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>May 15, 1900</b>	9. AGE (In years last birthday) <b>49</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Thomas L. Hoover</b>			14. MOTHER'S MAIDEN NAME <b>Ada L. Crouse</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT ADDRESS <b>Mr. Harry B. Urey 3908 Belle Ave.</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>Sub-arachnoid hemorrhage</b> DUE TO  (B) <b>Hypertensive cardiovascular disease</b> DUE TO  (C)		INTERVAL BETWEEN ONSET AND DEATH  <b>6 days</b>
---	--	--	---

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3-13</b> , 19 <b>50</b> to <b>3-19</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-19</b> , 19 <b>50</b> , and that death occurred at <b>11:05 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Katharine V. Kinn</b>		23B. ADDRESS <b>West Baltimore Gen. Hosp.</b>		23C. DATE SIGNED <b>3/19/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Black Rock Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Butler, Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>WM. J. TICKNER &amp; SONS Balto., Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 21 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Tickner</b>			



CERTIFICATE OF DEATH

105



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARY EVELYN RUTLEY

2. DATE  
OF  
DEATH

3-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

West Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

605 Mt. Holly St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar. 15, 1925

9. AGE (In years  
last birthday)

25

10. Under 1 Year  
Months Days

11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Kaminski

14. MOTHER'S MAIDEN NAME

Ida Fiedler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Robert R. Rutley

ADDRESS

605 Mt. Holly St.

18. 592X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

acute and

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN

ONSET AND DEATH

acute episode

approx. 2 wks.

chronic -

duration unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16-50, 1950, to 3-20, 1950, that I last saw the deceased alive on 3-20, 1950, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Shear

M. D.

23B. ADDRESS

W 1234

23C. DATE SIGNED

3-19-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 21 1950

Washington, Williams, O O O

WM. J. BICKNER & SONS

Balto., Md.



—

100

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

41. 7. 2.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2611

1. NAME OF DECEASED  
(Type or Print)

GOLDSBOROUGH, WILLIAM FITZHUGH

2. DATE  
OF  
DEATH

3/19/50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

BALT.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

11-01

O. STREET ADDRESS (If rural, give location)

PRESTON APTS; 21 E. PRESTON ST.

Length of stay in Baltimore

76 Yrs

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

6 MAY 1873

9. AGE (In years last birthday)

76

11 Under 1 Year Months Days

12 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES GOLDSBOROUGH

14. MOTHER'S MAIDEN NAME

MARY GALT.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT ADDRESS

MRS. RANDALL

DAUGHTER - CARROLL

3948 Preston Rd.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Cerebro-vascular accidents

4 mo

4 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized A-S & hypertension

DUE TO

11

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/19, 1950, to 3/19, 1950, that I last saw the deceased alive on 3/19, 1950, and that death occurred at 11 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William C. Ransom

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

March 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

Mar 22/50

24C. NAME OF CEMETERY OR CREMATORY

Wilmington Brandywine

24D. LOCATION (City, town, or county) (State)

Wilmington Del.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 21 1950

REGISTRAR'S SIGNATURE

Wilmington, Delaware

25. FUNERAL DIRECTOR

Henry J. Jenkins, Jr. 4905 York Rd

ADDRESS

4905 York Rd



UNITED STATES OF AMERICA  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WYOMING  
COUNTY OF TETON

SECTION 36  
TOWNSHIP 14 N  
RANGE 10 E

SECTION 36  
TOWNSHIP 14 N  
RANGE 10 E

SECTION 36  
TOWNSHIP 14 N  
RANGE 10 E

SECTION 36  
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SECTION 36  
TOWNSHIP 14 N  
RANGE 10 E

SECTION 36  
TOWNSHIP 14 N  
RANGE 10 E

SECTION 36  
TOWNSHIP 14 N  
RANGE 10 E







DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

U. S. A.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*ROSE C. HARDING*

2. DATE  
OF  
DEATH

*Mar 19 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Doctors Hospital  
49 2724 N. Charles St*

Length of stay in Baltimore

*50 yrs.*

5. SEX

*F.*

6. COLOR OR RACE

*W.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

*own home*

13. FATHER'S NAME

*Edward Slade*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write: RURAL and give township)

*Ind  
Baltimore 9-05*

D. STREET ADDRESS (If rural, give location)

*1325 Gorsuch ave*

8. DATE OF BIRTH

*Dec 20 1867*

9. AGE (In years last birthday)

*82 yrs*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

*England*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

14. MOTHER'S MAIDEN NAME

*Amelia Porter*

17. INFORMANT

ADDRESS

*Mrs. M.A. Hickman 1325 Gorsuch ave*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Occlusion*

*3-4 hrs*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Chronic Arteriosclerosis*  
(C) *with Hardened Arteries*

*5-10 yrs*

*3-4 yrs*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *August 31, 1948* to *March 19, 1950*, that I last saw the deceased alive on *March 19, 1950*, and that death occurred at *11 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Burial*

*Mar 22/50*

*Parkwood*

*Balto., Ind*

*MAR 21 1950*

*Wm. H. Jenkins, Jr.*

*Henry W. Jenkins & Sons 4905 York Rd*

MEDICAL CERTIFICATION

Write the causes of death clearly and legibly.



10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DOROTHY BEALL COGSWELL

2. DATE  
OF  
DEATH

MAR. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

3914 CLOVERHILL RD.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission.)  
A. STATE  
B. COUNTY

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

3914 CLOVERHILL RD.

Length of stay in Baltimore

35 Yrs

Yrs.  
Mos.  
Days

SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

FEB. 29, 1896

9. AGE (In years,  
last birthday)

54

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

BEALL

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

LATROBE COGSWELL

ADDRESS

SAME

18. 163X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Carcinoma of Lung.

Five months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Terminal Pneumonia

5 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Jan 15th 1949

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Lung (Re. upper lobe)

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☒ HOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from Jan 15th 1949, to March 20th 1950, that I last saw the deceased alive on March 19th 1950, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

H. C. Chatman

M. D.

23B. ADDRESS

15 E. Biddle St

23C. DATE SIGNED

March 21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

3-22-1950

24C. NAME OF CEMETERY OR CREMATORY

GREENMOUNT

24D. LOCATION (City, town, or county)

BALTO.

MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. C. Chatman

25. FUNERAL DIRECTOR

H. W. JENKINS &amp; SONS

ADDRESS

4905 YORK RD.

MAR 21 1950

47D







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FRANCIS ASBURY BLADES

2. DATE  
OF  
DEATH

Mar. 20, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Home for the Aged of the Meth. Ch.  
2211 W. Rogers Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

a. STATE

b. COUNTY

Md.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

d. STREET ADDRESS (If rural, give location)

2211 W. Rogers Ave.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Dec. 26, 1870

9. AGE (In years  
last birthday)

79

10. Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

never worked

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas W. Blades

14. MOTHER'S MAIDEN NAME

Sue Ann Dutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Miss Miriam O. Coates, Supt. 2211 W. Rogers Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma of Bladder

6 MONTHS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from October 1, 1949, to March 20, 1950 that I last saw the  
deceased alive on March 20, 1950, and that death occurred at 7:20 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/22/50

Mt. Carmel Cem.

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

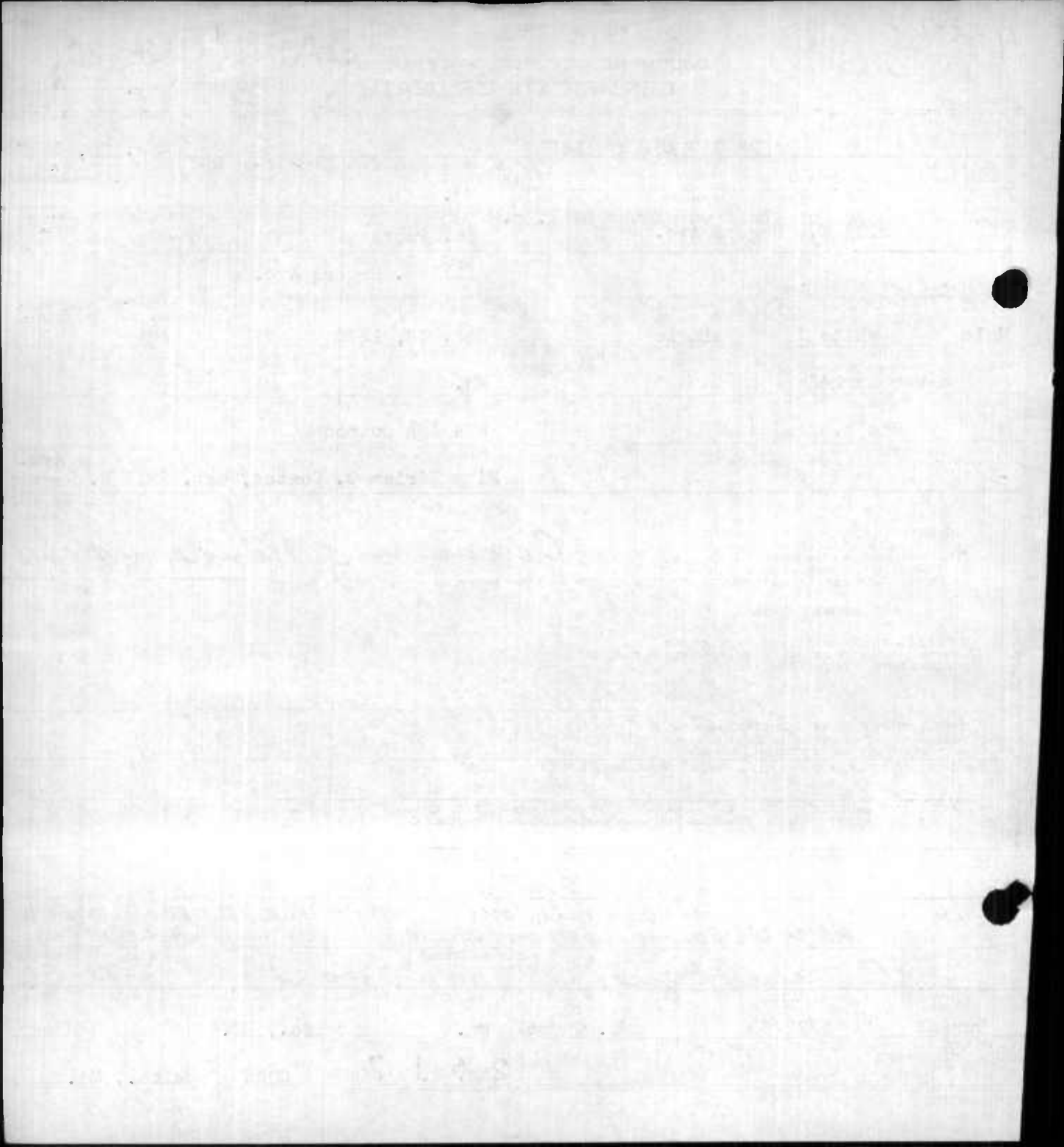
MAR 21 1950

Anthony J. Davies

2206 J. I. TICKNER &amp; SONS

Balto., Md.







The cause of death clearly and legibly.

360  
50 2616

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2616  
Registered No. 3698

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		SALLIE JETER		MARCH 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
1201 WINCHESTER STREET			MARYLAND		
			B. COUNTY		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			1201 WINCHESTER STREET		
Length of stay in Baltimore		35 yrs			
SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months Days
FEMALE	NEGRO	WIDOWED	AUGUST 1, 1883	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE			CULPEPER, VIRGINIA	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE H. FITZHUGH			ADELINE CARTER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		-----	GEO. BAILEY-1201 WINCHESTER STREET		

18. 443X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Myocarditis		Unknown	
DUE TO					
ANTECEDENT CAUSES		(B) Arterio Sclerosis & Hypertension		Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-18-1950, to 3-18-1950, that I last saw the deceased alive on 3-18-1950, and that death occurred at 2 P. m., from the causes and on the date stated above.

23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Frank A. Saunders M. D.		1629 N. Stricker St.		3-20-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	3/22/50			CULPEPER, VIRGINIA	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
MAR 21 1950		The Charles R. Law Mortuary		802-04 MADISON AVENUE BALTIMORE 1, MD.	



UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY

MARCH 1944

100-100000

MEMORANDUM

FOR THE RECORD

35-100

AUGUST 1, 1943

100-100000

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

100-100000-100000

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correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item or information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2617  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John A. Griffith

2. DATE  
OF  
DEATH

3/21/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

2608 Guilford Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2608 Guilford Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Gardner

10b. KIND OF BUSINESS OR  
INDUSTRY

Landscape

11. BIRTHPLACE (State or foreign country)

Delaware

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Griffith

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John A. Griffith 2608 Guilford Ave

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Suburularis Pulma

20y

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from 1950, to May 21, 1950, that I last saw the  
deceased alive on May 14, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Arthur J. Mer

M. D.

23B. ADDRESS

1208 E. Belvidere

23C. DATE SIGNED

3/21/50

24A. BURIAL/CREMA-  
TION/REMOVAL (Specify)

Burial

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill

24D. LOCATION (City, town, or county)

Towson

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

Arthur J. Mer

1217 St. Paul St.



1200 5 10 10



correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

WILLIAM M. SMITH

2. DATE  
OF  
DEATH

Mar. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3017 Eastern Ave.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

219 E. Lake Ave.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Oct. 4, 1880

9. AGE (In years  
last birthday)

69

11 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Supervision, retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Balt Transit Co

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David M. Smith

14. MOTHER'S MAIDEN NAME

Elizabeth (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William M. Smith, Jr., 4022 Alameda Blvd

18. 4200

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

CORONARY THROMBOSIS

DUE TO

ARTERIOSCLEROTIC HEART DISEASE  
CORONARY INSUFFICIENCY  
BRACHIAL HYPERTENSION

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from July 1948 to 19 March, 1950, that I last saw the deceased alive on 19 March 1950, and that death occurred at 10:40 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oak Lawn

Baltimore County, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

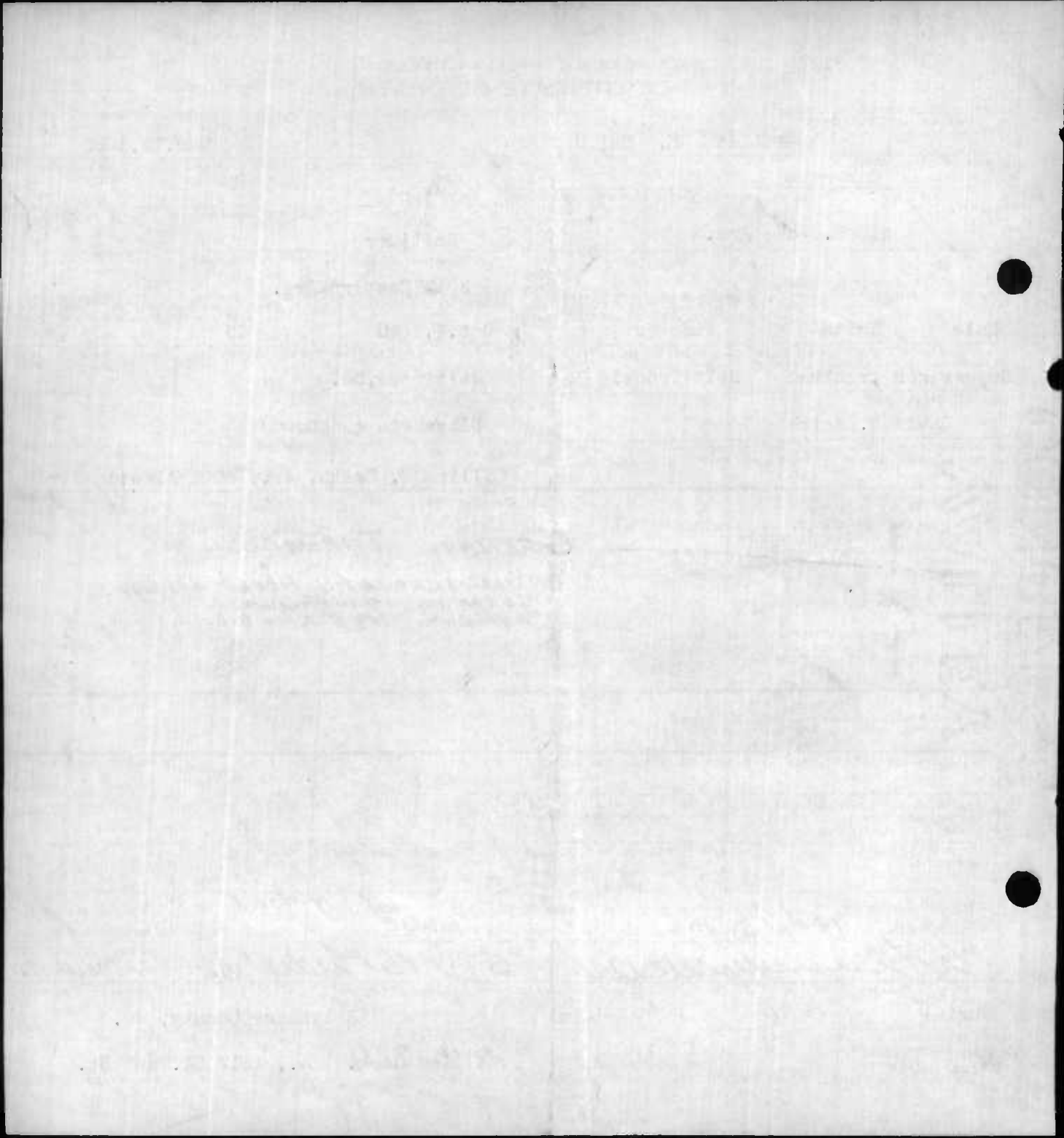
William Cook, Inc., 1217 St. Paul St.

MAR 22 1950

156 49

937







Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

W-400 50 2619

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2619  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <i>Maud Wile</i>	
2. DATE OF DEATH <i>3-22-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Hospital for Women of Maryland</i>	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>White Hall, Maryland</i>	
D. STREET ADDRESS (If rural, give location)	
E. Length of stay in Baltimore	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	
8. DATE OF BIRTH <i>Sept. 26, 1871</i>	
9. AGE (In years last birthday) <i>78</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Thomas Nelson</i>	
14. MOTHER'S MAIDEN NAME <i>Isabel Ashton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS	

MEDICAL CERTIFICATION	18. <i>159X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH (A) <i>Gastro-Intestinal Hemm.</i> DUE TO (B) <i>Hypertensive Cardio-Vascular Dis.</i> DUE TO (C) <i>?? Malignancy GI Tract</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>25 yrs.</i>
	19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION
	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
	21F. HOW DID INJURY OCCUR?		
	22. I hereby certify that I attended the deceased from <i>3-21</i> , 19 <i>50</i> , to <i>3-22</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-22</i> , 19 <i>50</i> , and that death occurred at _____ m., from the causes and on the date stated above.		
	23A. SIGNATURE <i>John R. Smith, Jr.</i>		23B. ADDRESS <i>Hosp. for Women of Md. Bldg. Md.</i>
	23C. DATE SIGNED <i>3/22/50</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 21-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Bethel</i>		24D. LOCATION (City, town, or county) (State) <i>White Hall Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 22 1950</i>		25. FUNERAL DIRECTOR'S ADDRESS <i>Howard S. Macklin White Hall Md.</i>	



MEMORANDUM FOR THE SECRETARY

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 2620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2620

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Edward H. Ruffin.*

2. DATE  
OF  
DEATH

*March 21 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Baltimore*

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*Maryland.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*17 Murdock Rd.*

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*Sept. 27 1914*

9. AGE (In years last birthday)

*35*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Civil Engineer*

10B. KIND OF BUSINESS OR INDUSTRY

*Falsant - Kooker Co.*

11. BIRTHPLACE (State or foreign country)

*Prince George Co. Virginia.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*George C. Ruffin.*

14. MOTHER'S MAIDEN NAME

*Sarah Harrison*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*yes*

*World War II*

16. SOCIAL SECURITY NO.

*224-01-2240*

17. INFORMANT

*Corinna R.W. Ruffin 17 Murdock Rd Balto. 12-Md*

18.

*153X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Metastatic Carcinoma*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*3 mo.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Mucoid carcinoma of transverse colon.*

DUE TO

*1 yr?*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

*March 18 1950*

19B. MAJOR FINDINGS OF OPERATION

*Metastatic Carcinoma - Previous - Previous operation 3 mo.*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3-15*, 19*50*, to *3-21*, 19*50*, that I last saw the deceased alive on *3-20*, 19*50*, and that death occurred at *12:30* Am., from the causes and on the date stated above.

23A. SIGNATURE

*H. Harrison Mack.*

23B. ADDRESS

*University Hospital*

23C. DATE SIGNED

*3-21-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 23-50*

24C. NAME OF CEMETERY OR CREMATORY

*Baltimore National*

24D. LOCATION (City, town, or county) (State)

*Baltimore*

*Md*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 22 1950*

REGISTRAR'S SIGNATURE

*Wilmington, Delaware, Md.*

25. FUNERAL DIRECTOR

*R.F. Ellice & Sons, Rustertown, Md.*

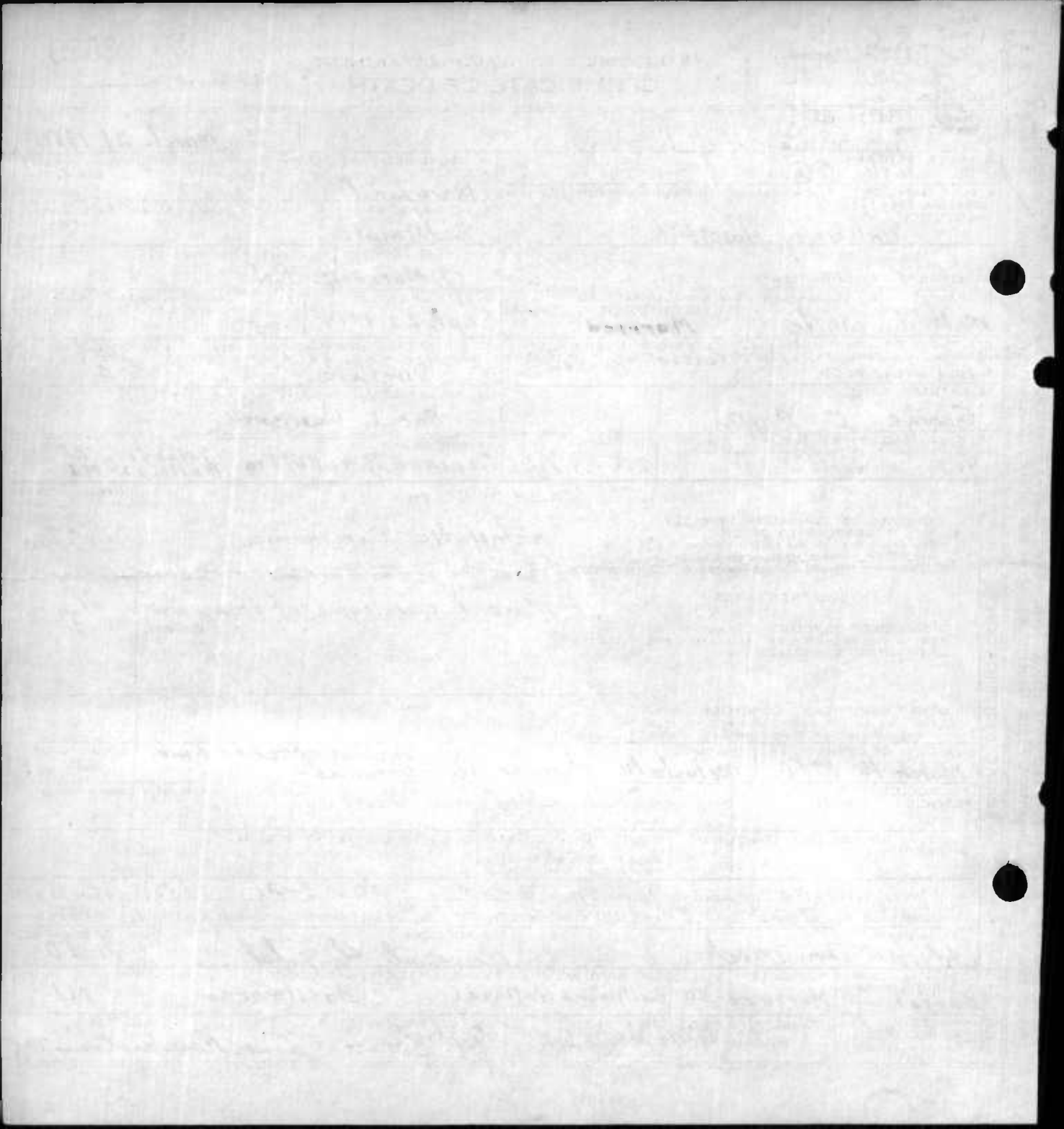
ADDRESS

VS 150

V1693

46E







PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2621  
Registered No. 2621

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland  
(b) Street address 917 S. Baylis St.  
(c) Hospital or institution:  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State md (b) County 26-09  
(c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. 917 S. Baylis St.  
(If rural give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

Seth Coleman

## 3 (b) If veteran, name war

## 3 (c) Social Security Account No.

## 4. Sex

M

## 5. Color or race

Col

## 6 (a) Single, married, widowed, or divorced.

Married

## 6 (b) Name of husband or wife

Emmerline

## 6 (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

3/17/72

## 8. AGE: Years

78

## Months

## Days

## If less than one day

hr.

min.

## 9. Birthplace

Va  
(Town, county, and state)

## 10. Usual Occupation

## 11. Industry or business

## FATHER

## 12. Name

Willis Coleman

## 13. Birthplace

Va

## MOTHER

## 14. Maiden Name

Martha ?

## 15. Birthplace

Va

## 16 (a) Informant

Emmerline Coleman

## (b) Address

917 S. Baylis St.

## 17 (a)

Swirl

(Burial, cremation, or removal)

(b) Date thereof 3/22/50

(month) (day) (year)

## (c) Cemetery or crematory

mt Calvary Cem

## Location

Ch. A. Co., Md.

## 18 (a) Funeral director

Robert Williams

## (b) Address

1515 McElroy St.

## 19 (a)

Mar 22 1950

(Date rec'd by registrar)

Huntington Williams

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 18

1950, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1947, to March 18 1950, and that I last saw him alive on March 18, 1950.

## Immediate cause of death

Chronic mitral regurgitation

## Duration

?

Due to Chronic bronchitis

?

Due to Chronic Nephritis

?

Other Conditions Senile gangrene, right foot

(Include pregnancy within 3 months of death)

Date of operation February 22, 1950

Major findings of operation: Lateral side of rt. foot removed and left open.

of autopsy:

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

I. B. Bronushas, M.D.

(e) Means of injury Medical Officer, U.S.P.H.S.

23. Signature

I. B. Bronushas, M.D.

Address 3037 O'Donnell St.

Date signed

3-21-50



## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JOSHUA A. BAXTER

2. DATE  
OF  
DEATH

MARCH 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2113 PULASKI STREET - N.

c. Length of stay in Baltimore

25 Yrs

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

July 4, 1896

9. AGE (In years,  
last birthday)

53

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

MACHINE OPERATOR

10B. KIND OF BUSINESS OR  
INDUSTRY

CHEMICAL PLANT

11. BIRTHPLACE (State or foreign country)

NORFOLK, VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ELI BAXTER

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

218-09-4985

17. INFORMANT

ADDRESS

CORNELIA CADE-2113 PULASKI STREET

18.

157X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)  
DUE TO

Carcinoma of Pancreas  
(Papillary adenocarcinoma)

INTERVAL BETWEEN  
ONSET AND DEATH

Gravely ill

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

12-14-49

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Pancreas

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12, 1950, to 3-20, 1950, that I last saw the  
deceased alive on 19, and that death occurred at 6:45 p. m., from the causes, and on the date stated above.

23A. SIGNATURE

Charles R. Law

M. D.

23B. ADDRESS

861 Harrison Ave

23C. DATE SIGNED

3-20-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

NORFOLK, VIRGINIA

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

THE CHARLES R. LAW MORTUARY

VS 150

802-04 MADISON AVENUE

BALTIMORE 1, MD.

49617

469



2228



630  
50 2623

HOWARD

50 2623

Registered No.

630  
50 2623

VS 150

44429

BALTIMORE 1, MD. 131a

BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
John Howard		March 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE	
JOHNS HOPKINS HOSPITAL		Md.	
C. CITY OR TOWN		B. COUNTY	
13 Baltimore		12-07	
D. STREET ADDRESS (If rural, give location)		C. CITY OR TOWN	
2122 N. Howard St		13 Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
5. SEX		6. COLOR OR RACE	
Male		Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Married		8-26-03	
9. AGE (In years last birthday)		10. UNDER 1 Year	
46		Months: Days	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RAINBOW, VIRGINIA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN HOWARD		CATHERINE WEBSTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		213-07-9755	
17. INFORMANT		ADDRESS	
MAGGIE HOWARD		2122 N. HOWARD ST.	
18. 442X			
CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			
(A) Hypertensive cardiovascular renal disease.			
DUE TO			
(B) Uremia			
DUE TO			
(C)			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 3-11-1950 to 3-19-1950, that I last saw the deceased alive on 3-19-1950, and that death occurred at 6:00 m., from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	
William W. Winterh		JOHNS HOPKINS HOSPITAL	
23C. DATE SIGNED		3/19/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		3/22/50	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
ARBUTUS MEMORIAL PARK		ARBUTUS, MARYLAND	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
MAR 22 1950		The CHARLES R. LAW MORTUARY	
502-04 MADISON AVENUE		BALTIMORE 1, MD.	



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH



50 2624

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2624

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR JAMES CARTER

2. DATE  
OF  
DEATH

MARCH 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1403 MYRTLE AVENUE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

BALTIMORE

township)

D. STREET ADDRESS (If rural, give location)

1403 MYRTLE AVENUE

c. Length of stay in Baltimore

30 yrs

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9/15/1890

9. AGE (In years

last birthday)

59

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LONGSHOREMAN

10B. KIND OF BUSINESS OR

INDUSTRY

STEAMSHIP CO.

11. BIRTHPLACE (State or foreign country)

LANCASTER, VIRGINIA

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

MARY HILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

216-05-8024

17. INFORMANT

ADDRESS

CATHERINE E. CARTER-1403 MYRTLE AVE

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1950, to 3-19, 1950, that I last saw the  
deceased alive on 3-19, 1950, and that death occurred at 8 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

MOUNT AUBURN CEMETERY

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

VS 150

THE CHARLES R. LAW MORTUARY

802-04 MADISON AVENUE

BALTIMORE 1, MD.

83a

90651

MEDICAL CERTIFICATION

PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.







Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

50 2625

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2625

Registered No.

BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Henry Adams</i>			2. DATE OF DEATH <i>Mar. 19-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>6012 Bertram Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-05</i>		
D. STREET ADDRESS (If rural, give location) <i>6012 Bertram Avenue</i>			E. Length of stay in Baltimore Yrs. Mos. Days		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Jan. 15-1889</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoe Cutter</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>ELEC. TOOLS (M)</i>		
11. BIRTHPLACE (State or foreign country) <i>England</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>?</i>			14. MOTHER'S MAIDEN NAME <i>?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs. Mary E. Adams</i>			ADDRESS <i>6012 Bertram</i>		
18. <i>151X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Carcinoma Stomach</i> 1 year DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Oct 1949</i>		19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma Stomach, Inoperable</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov. 1949</i> to <i>3-19</i> , 1950 that I last saw the deceased alive on <i>3-13</i> , 1950 and that death occurred at <i>5:40 AM</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>C. W. Peake</i>		23B. ADDRESS <i>4518 Harford Road</i>		23C. DATE SIGNED <i>3-20-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/27/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bald National</i>	
24D. LOCATION (City, town, or county) (State) <i>Bald Md</i>		25. FUNERAL DIRECTOR <i>L. J. Luck</i>		ADDRESS <i>5305 Harford Rd</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 22 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. H. Williams, M.D.</i>			

VS 150

39637

46B



Dr. Reake.

1882



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2626

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **John Douglas Alexander** 2. DATE OF DEATH **March 20, 1950**

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION **Mercy Hospital, doa** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** **12-04**

D. STREET ADDRESS (If rural, give location) **113 E. 21 1/2 St.**

E. Length of stay in Baltimore Yrs. Mos. Days

5. SEX **Male** 6. COLOR OR RACE **C** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Separated** 8. DATE OF BIRTH **Dec. 24 1912** 9. AGE (In years last birthday) **37** 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Helper** 10B. KIND OF BUSINESS OR INDUSTRY **Moving Van** 11. BIRTHPLACE (State or foreign country) **Middleburg N.C.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Plummer Alexander** 14. MOTHER'S MAIDEN NAME **Frances Jones**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **no.** (If yes, give war or dates of service) **none** 16. SOCIAL SECURITY NO. **2-17-01-6159** 17. INFORMANT **John Douglas Alexander** ADDRESS **Henderson N.C.**

18. **002 X** I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH **Pulmonary Tuberculosis**

ANTECEDENT CAUSES (A) DUE TO (B) DUE TO (C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Insp. & Inc.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE **Earl R. Roy** 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **March 20, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Shipped** 24B. DATE **3/22/50** 24C. NAME OF CEMETERY OR CREMATORY **Henderson N.C.** 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR **MAR 22 1950** REGISTRAR'S SIGNATURE **W. Halstead** 25. FUNERAL DIRECTOR **W. Halstead** ADDRESS **98850 Walnut Hill Ave. 12B**



CERTIFICATE OF BIRTH

STATE OF NEW YORK

County of ...

City of ...

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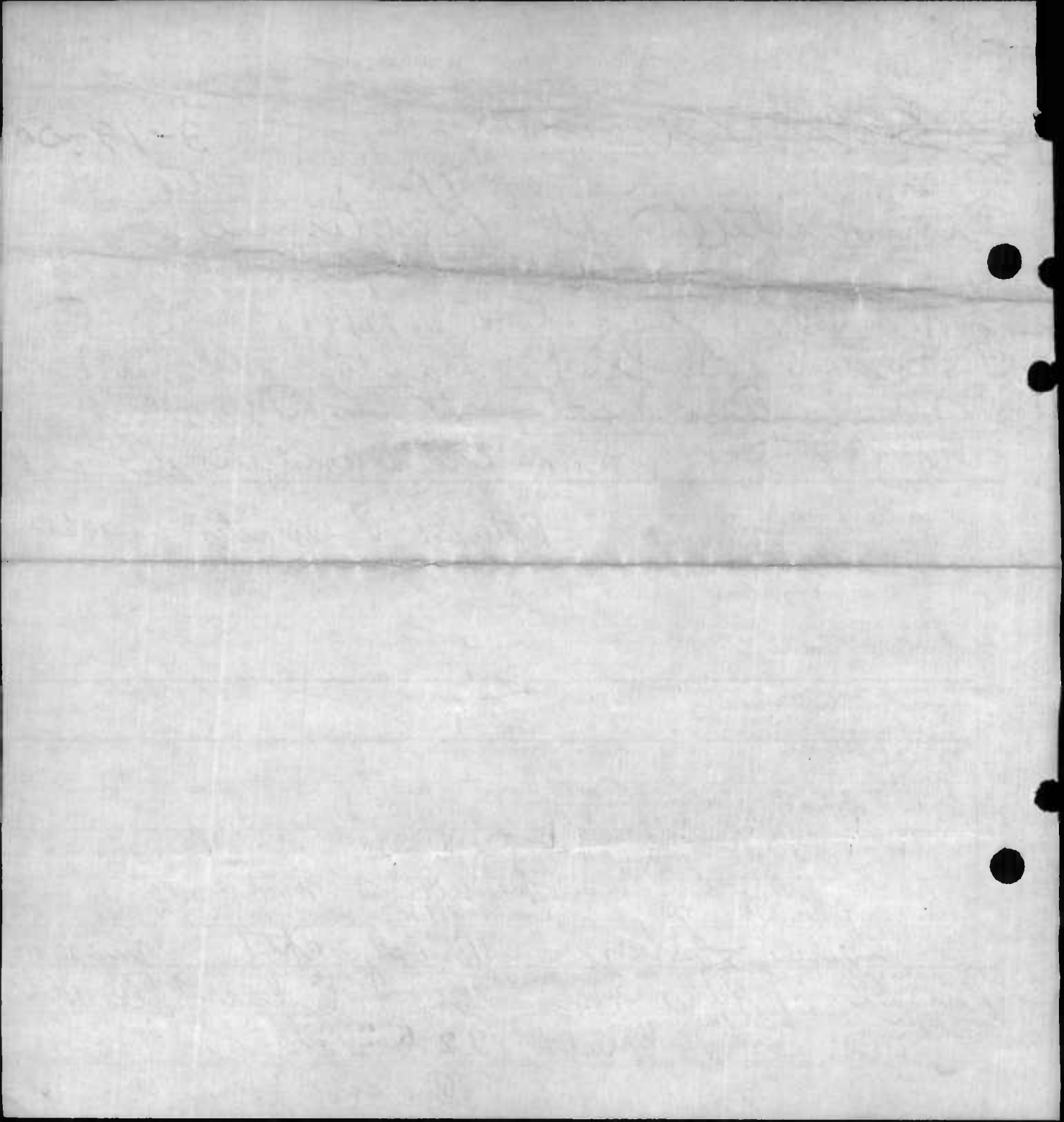


PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED FOR BIRTH

50 2627		BALTIMORE CITY HEALTH DEPARTMENT		50 2627	
BIRTH No. 49-26709		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Carl Andrews</i>			2. DATE OF DEATH <i>3-19-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>City</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hosp.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 4-02</i>		
C. Length of stay in Baltimore <i>3</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>770-Sarah Ann St</i>		
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Infant</i>	8. DATE OF BIRTH <i>Dec. 12/1949</i>	9. AGE (In years last birthday) <i>3</i>	If Under 1 Year: Months <i>3</i> Days <i>7</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>	11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Morris Andrews</i>			14. MOTHER'S MAIDEN NAME <i>Edith Planter</i> ✓		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>none</i>	17. INFORMANT ADDRESS <i>Edith Andrews-Sarah Ann St</i>		
18. <i>492X</i> CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Extensive Pneumonia</i> DUE TO					
ANTECEDENT CAUSES (B) _____ DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 19, 1950</i> , to <i>March 19, 1950</i> that I last saw the deceased alive on <i>March 19, 1950</i> and that death occurred at <i>11 A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Morris Andrews</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>March 20, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/24/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Cedar Hill Md.</i>		24E. NAME OF FUNERAL DIRECTOR <i>W. H. Halstead</i>		24F. ADDRESS <i>918 - Alcega Hill Ave. 1090</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 22 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams</i>		25. FUNERAL DIRECTOR ADDRESS	
VS 150					







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2628  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louise

Neal

2. DATE  
OF  
DEATH

March 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write LOCAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

322 - Preston St. W.

E. Length of stay in Baltimore

1942 Yrs.  
Mos.  
Days

5. SEX  
F

6. COLOR OR RACE  
C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Oct. 7, 1921

9. AGE (In years  
last birthday)

28

10. Under 1 Year  
Months: Days: Hours: Min.

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

13. FATHER'S NAME

Charles Askeew

14. MOTHER'S MAIDEN NAME

Elena Askeew

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Chas. Askeew - 908 - 13th Ave.

18. 002X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ HOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Emil Rye

23B. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER  
M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED

March 17, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/22/50

24C. NAME OF CEMETERY OR CREMATORY

St. Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 22 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

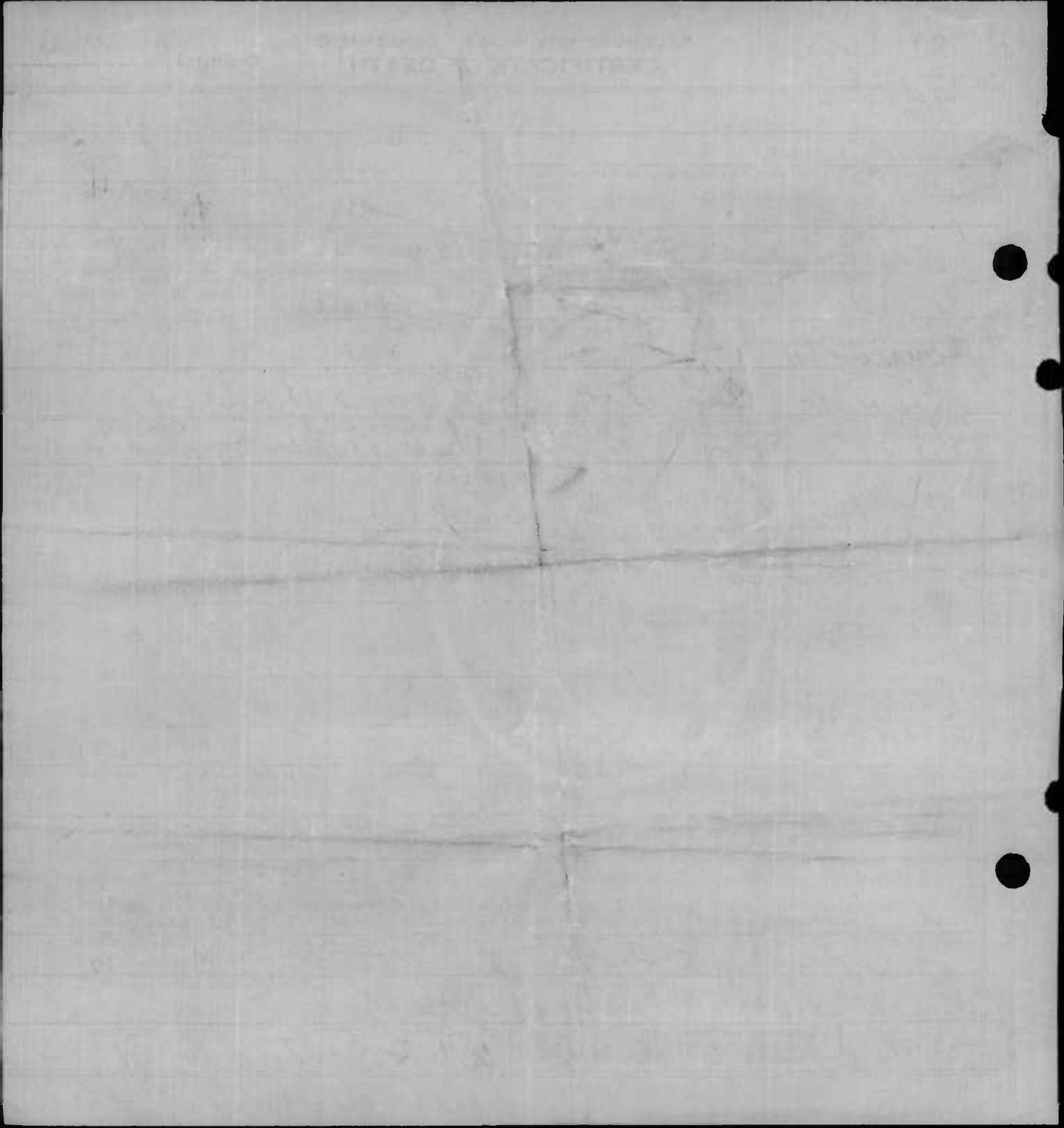
25. FUNERAL DIRECTOR

W. H. Halstead - 918 -

ADDRESS

Elmwood Hill Ave. 13B







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

522

50 2629

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2629

Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>Marshall Winchester</b>			2. DATE OF DEATH <b>MAR 21 1950</b>					
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY								
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>								
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>1202 Eutaw Place, Apt. 2A</b>								
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>	8. DATE OF BIRTH <b>12-14-68</b>		9. AGE (In years, last birthday) <b>81</b>		10. Under 1 Year Months: Days		11. Under 24 Hours Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Banker</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>John Marshall Winchester</b>			14. MOTHER'S MAIDEN NAME <b>Anne Gordon Price</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>			ADDRESS		
18. <b>490X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Lobar pneumonia, RUL</b> DUE TO			CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized arteriosclerosis</b> DUE TO											
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <b>3-8-1950</b> to <b>3-21-1950</b> , that I last saw the deceased alive on <b>3-21-1950</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.											
23A. SIGNATURE <b>Ernest C. Brown Jr.</b> M. D.				23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				23C. DATE SIGNED <b>3/21</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar 23, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. John's Waverly</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 22 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>		25. FUNERAL DIRECTOR <b>2434 W. 3rd St</b>		ADDRESS <b>Son 8057 Calvert St</b>					







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 2630

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2630  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ABRAM DAVIS

2. DATE  
OF  
DEATH

March 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

US Marine Hospital

57 Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore

?

Yrs.  
Mos.  
Days

5. SEX  
M

6. COLOR OR RACE  
W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Div.

8. DATE OF BIRTH  
11/28/03

9. AGE (In years last birthday) 46  
If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AB seaman

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

NC

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Davis

14. MOTHER'S MAIDEN NAME

Bertha Ann Twiddy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL SECURITY NO.  
223-07-2229

17. INFORMANT ADDRESS  
Records- US Marine Hospital, Balto, Md.

18. 162X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiogenic carcinoma

DUE TO

2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Empyema

DUE TO

Recent

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 17, 1950, to Mar. 19, 1950, that I last saw the deceased alive on Mar. 19, 1950, and that death occurred at 6:45P.m., from the causes and on the date stated above.

23A. SIGNATURE  
John L. Wilson, Medical Director

23B. ADDRESS  
US Marine Hospital, Balto, Md.

23C. DATE SIGNED  
3/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/23/50

Woodlawn

Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

Funeral Home

Paul & Son 3615-17 Chestnut Ave

46051

47C







50 2631

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2631

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Spence, Mattie M.

2. DATE  
OF  
DEATH

3/21/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4108 Groveland Ave

6. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Fe

6. COLOR OR RACE

white

7. SINGLE MARRIED,  
WIDOWED DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

March 5, 1891

9. AGE (In years,  
last birthday)

59

H Under 1 Year  
Months; DaysH Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR  
INDUSTRY

Seamstress Dress Mfg.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Huster

14. MOTHER'S MAIDEN NAME

Edith -

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Nora Spence 5704 Kenmore Rd. ✓

18. 416 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Embolism

DUE TO

20 years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Rheumatic Heart Disease

DUE TO

20 years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from March 9, 1950, to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 9<sup>15</sup> a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/24/50

Lorraine Cem.

Woodlawn, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

Huntington Williams, Md.

W. G. TICKNER &amp; SONS

Balto., Md.







correct age is especially important. Physicians: please write the causes of death clearly and legibly. The cause of death must be carefully supplied.

532  
50 2632

BALTIMORE CITY HEALTH DEPARTMENT

50 2632

CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*(Mathios)*  
Matthew Janoutis

2. DATE  
OF  
DEATH

3/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write JURAT and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

400 S. Oldham St #24

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, (MARRIED),  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1888

9. AGE (In years  
last birthday)

62

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

house painter

10B. KIND OF BUSINESS OR  
INDUSTRY

unemployed contractor

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF  
WHAT COUNTRY?

probably U.S.

13. FATHER'S NAME

George Janouria

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.

unknown

17. INFORMANT

Yus Janouria

ADDRESS

400 S. Oldham St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

myocardial infarction

INTERVAL BETWEEN  
ONSET AND DEATH

10 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

arteriosclerotic coronary  
thrombosis

10 hrs

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/19, 1950, to 3/20, 1950, that I last saw the  
deceased alive on 3/20, 1950, and that death occurred at 2:55 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John R. Hankins

M. D.

23B. ADDRESS

University Hospital, Balto-1

23C. DATE SIGNED

3/20/50

24A. BURIAL, CREM-  
ATION, REMOVAL (Specify)

24B. DATE

3-22-50

24C. NAME OF CEMETERY OR CREMATORY

Greek East

24D. LOCATION (City, town, or county)

Windsor Mill Rd

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington, Delaware

25. FUNERAL DIRECTOR

ADDRESS

Lanning Inc 440 E. North



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU

WASHINGTON, D. C.

RECEIVED

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2633

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

2633

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emanuel Ferrante

2. DATE  
OF  
DEATH

Mar. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1021 Ensor St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1021 Ensor St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 27, 1894

9. AGE (in years  
last birthday)

56

10. Under 1 Year  
Months: Days

1 21

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cement Finisher New Homes Co.

10B. KIND OF BUSINESS OR  
INDUSTRY

Cement Finisher New Homes Co.

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sebastian Ferrante

14. MOTHER'S MAIDEN NAME

Cecilia Asennoda

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

Yes

16. SOCIAL  
SECURITY NO.

214-03-1094

17. INFORMANT

Leon M. Ferrante

ADDRESS

1021 Ensor St.

18. 151 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Stomach  
with Extensive Mesenteric,  
para-aortic and liver  
metastases

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

6 months

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3/6/1950

19B. MAJOR FINDINGS OF OPERATION

Inoperable Carcinoma of Stomach &amp; Metast

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1950, to Feb 20, 1950, that I last saw the  
deceased alive on March 18, 1950, and that death occurred at 930 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John H. Hirschfeld M.D.

23B. ADDRESS

6919 Harbor Rd

23C. DATE SIGNED

3/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Mar 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 22 1950

REGISTRAR'S SIGNATURE

Huntington Wilson

25. FUNERAL DIRECTOR

Eduard W. Conklin

ADDRESS

924 E. Eager St.

VS 150

368 V9

4610



Don. H. H. H. H. H.  
6919 H. H. H. H. H.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

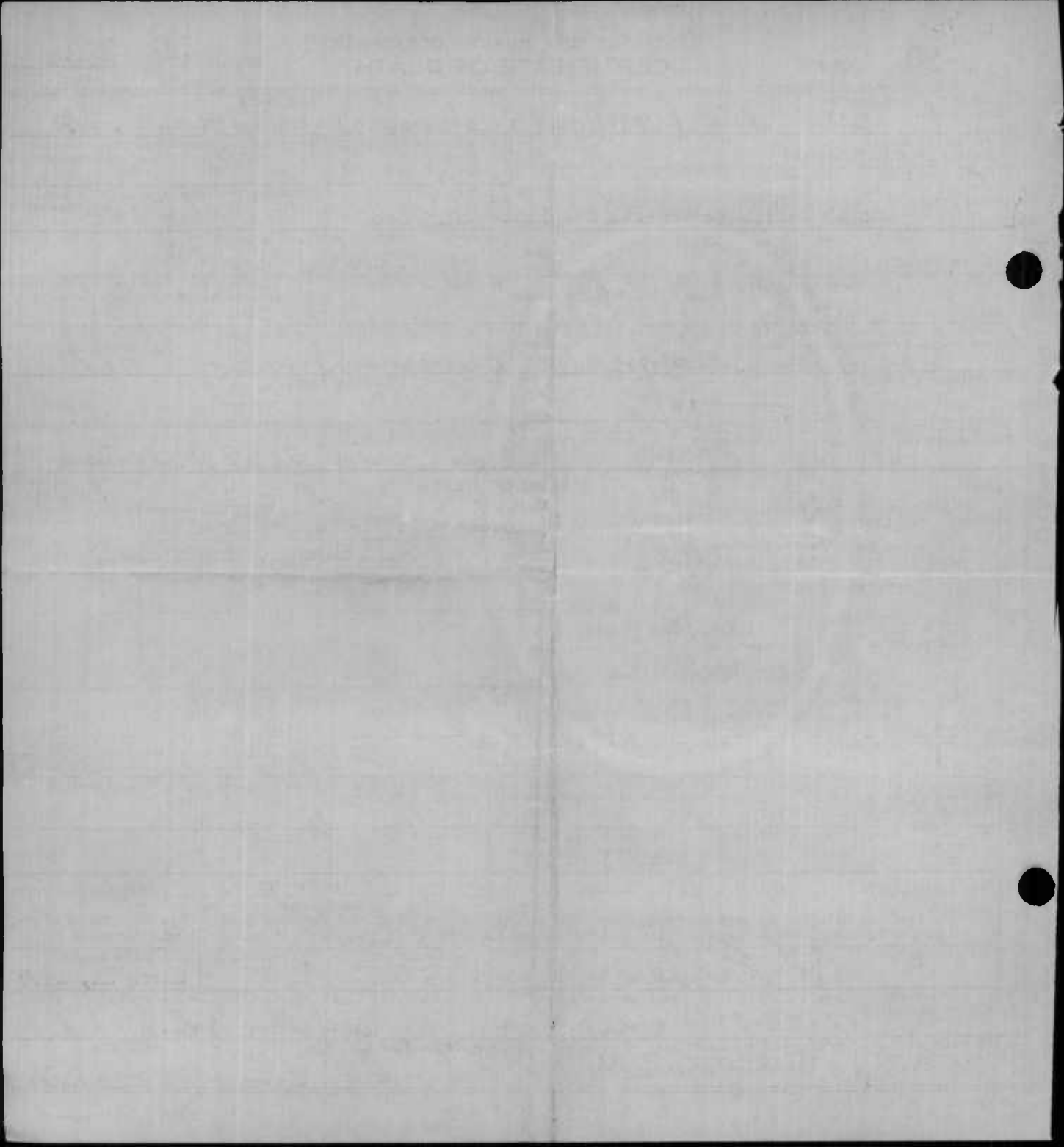
Registered No. **50 2634**

1. NAME OF DECEASED (Type or Print) <b>WILLIAM CANELOS (Vasilios Canelopoulos)</b>		2. DATE OF DEATH <b>March 20, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2029 W. Saratoga Street</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE (MARRIED) WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wholesale Office Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Smymna Turkey</b>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ads Canelos</b>		ADDRESS <b>2029 W. Saratoga St</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease with coronary insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>JPS Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/>		23C. DATE SIGNED <b>March 21, 1959</b>	
24A. (BURIAL) CREMATION, REMOVAL (Specify)		24B. DATE <b>3-23-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greek Cem</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 22 1950</b>		REGISTRAR'S SIGNATURE <b>William O. ...</b>		25. FUNERAL DIRECTOR <b>Lambert Inc 440 E. North</b>	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

450

50 2635

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2635  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. CHARLES QuILLAN

2. DATE  
OF  
DEATH

3/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

35 Church Home & Hospital

C. Length of stay in Baltimore

27

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
CITY INDUSTRY

Police Officer

13. FATHER'S NAME

Benjamin Quillan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

March 14, 1893

9. AGE (In years  
last birthday)

57

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Clark Homeny

17. INFORMANT

ADDRESS

Miss Frieda Victor 402 N. Rose St

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pulmonary Edema

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Myocardial Infarction

2 days

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/20, 1950, to 3/21, 1950, that I last saw the  
deceased alive on 3/21, 1950, and that death occurred at 3:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Eison

M. D.

23B. ADDRESS

Church Home & Hosp

23C. DATE SIGNED

3/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Burial Mar 24/50

24C. NAME OF CEMETERY OR CREMATORY

National Cem

24D. LOCATION (City, town, or county)

Balt

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington, Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1226 R. Funeral Home 2004 Bal

MAR 22 1950

VS 150

604 98

94a







N-452

50 2636

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2636

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillie Williams

2. DATE  
OF  
DEATH

3-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1146 Shields place

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
" "

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

none

13. FATHER'S NAME

Sam Smeal

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

Feb 1887

9. AGE (In years  
last birthday)

63

11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

American

14. MOTHER'S MAIDEN NAME

Mary Kellum

17. INFORMANT

ADDRESS

Mrs Gladys Rice 1146 Shields Pl

18. 4/20/1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary disease of heart

3 1/2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic valvular disease of heart

4 1/2 years

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21a. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-16-, 1949 to 3-13-, 1949 that I last saw the  
deceased alive on 3-12-, 1949, and that death occurred at 12 m., from the causes and on the date stated above.

23A. SIGNATURE

John E. L. Camper

M. D.

23B. ADDRESS

639 N. Carey St

23C. DATE SIGNED

3-18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/22/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Zion Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Hallam

25. FUNERAL DIRECTOR

ADDRESS

2 Charles A. Rice 661 W. Borne

correct age is especially important. Physicians write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



RECEIVED

MAR 20 1950

Chief Medical Examination Office



400  
50 2637BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2637

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret Kelly

2. DATE  
OF  
DEATH

March 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONSalem Suites 7th Floor  
Tromp for the aged4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

TOWSON

(If outside corporate limits, write RURAL and give township)

5200

c. Length of stay in Baltimore

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S.

Yes  
Mos.  
Days

8. DATE OF BIRTH

Sept 12, 1874

9. AGE (In years,  
last birthday)

75

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Companion-Secretary-Ref. Private Employee

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Michael Kelly

14. MOTHER'S MAIDEN NAME

Delia Dockery

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT Address

Sister Dymally  
1205 Valley St

18. 4222 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Edema Lungs

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic Myocarditis

5 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Cerebral Arterio Sclerosis

6 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 5, 1950, to March 20, 1950, that I last saw the  
deceased alive on March 20, 1950, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

E. G. Hall M.D.

23B. ADDRESS

16312 North Ave

23C. DATE SIGNED

March 20 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

MAR. 23, 1950 New Cathedral Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

ADDRESS

John Burns' Sons, Towson Md.

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







3-400  
50 2638

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2638  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph M. Bell

2. DATE  
OF  
DEATH

3-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist - Wash. Navy Yard

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Orrille H. Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-069845

17. INFORMANT

Elva M. Bell

ADDRESS

Same

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) RUPTURED VENTRICLE (LEFT)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/16, 1950, to 3/18, 1950, that I last saw the deceased alive on 3/18, 1950, and that death occurred at 5:56 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

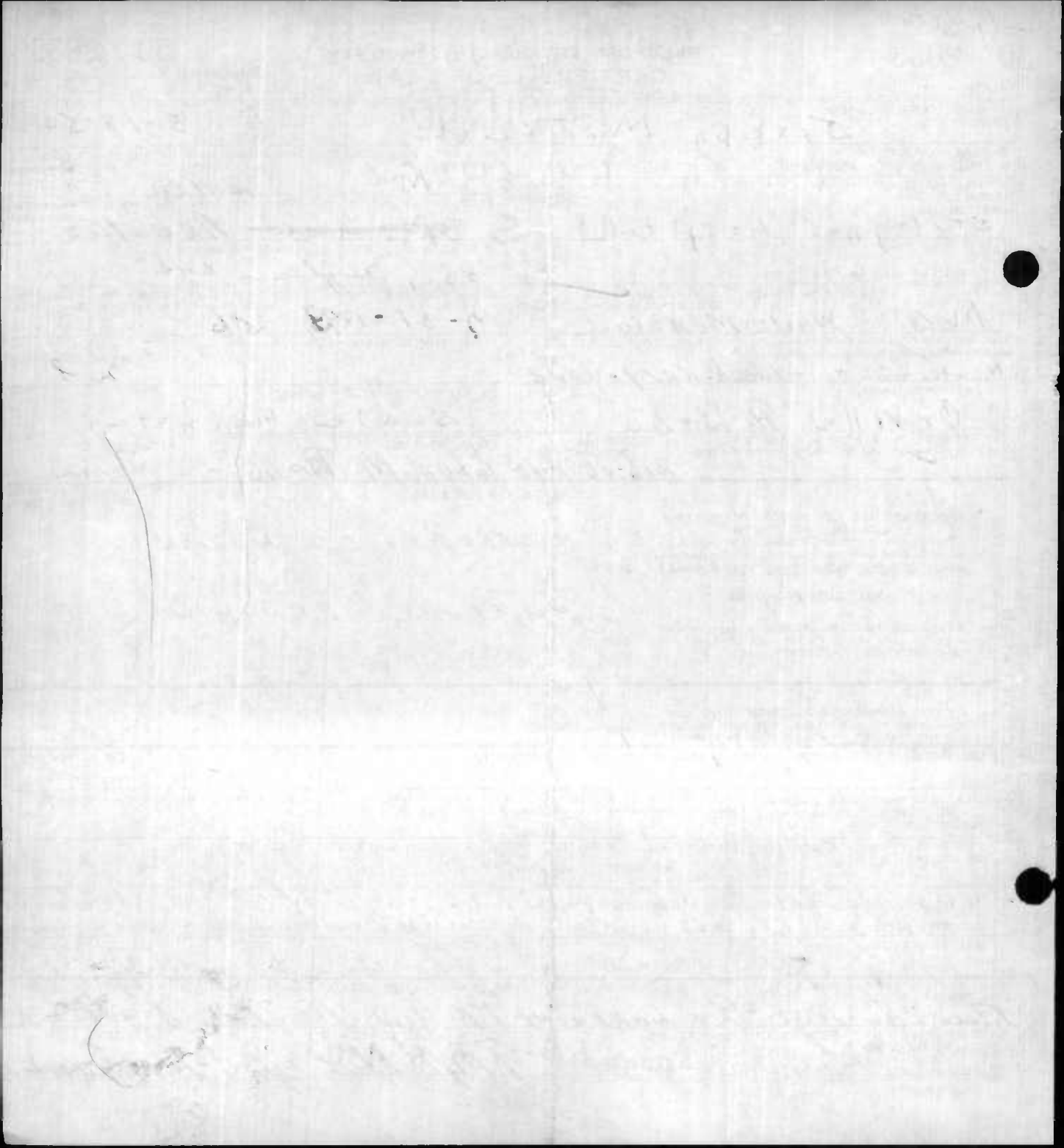
Wilmington

402

1200

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

536

50 2639

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2639

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick Snyder

2. DATE  
OF  
DEATH

March vi. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

C. Length of stay in Baltimore

S. SEX

m

6. COLOR OR RACE

w

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tool machinist

10B. KIND OF BUSINESS OR INDUSTRY

WESTERN ELECTRIC

13. FATHER'S NAME

ELLY (decd)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes WWII 1941-1945

16. SOCIAL SECURITY NO.

VI-03-1024

17. INFORMANT

EMMA E. Snyder

ADDRESS

same

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis, acute

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/20, 1950, to 3/21, 1950, that I last saw the deceased alive on 3/21, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

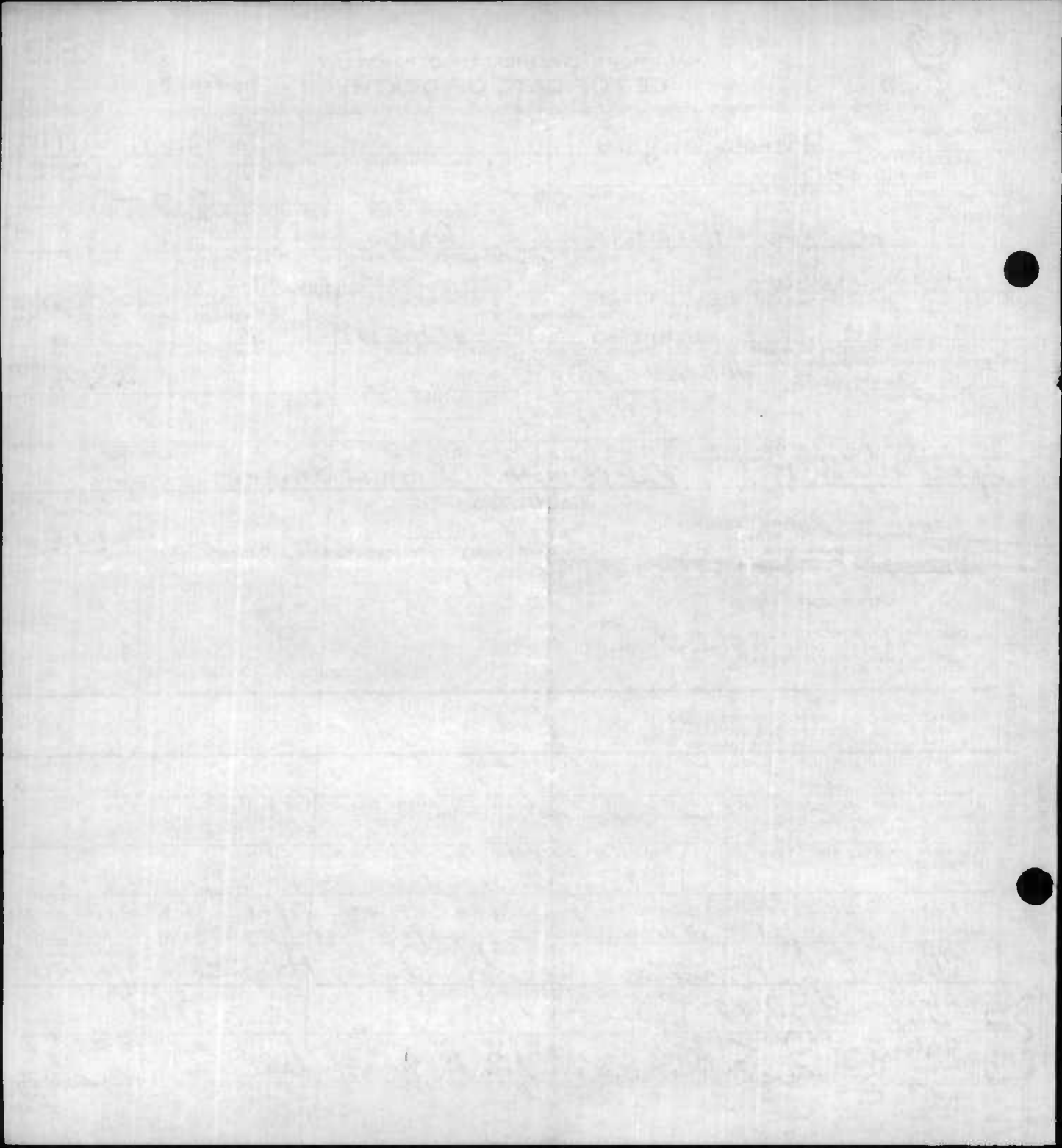
MAR 22 1950

Wilmington, Delaware

W. H. M. Walters

Stucker







562  
50 2640

50 2640

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Mary Emrick</i>		2. DATE OF DEATH <i>March 29, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baile, Md</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>105 S. Addison St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baile</i>	
D. STREET ADDRESS (If rural, give location) <i>105 S. Addison St.</i>			

Length of stay in Baltimore

5. SEX <i>F-</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Oct 12, 1886</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Year Months: Days	If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Torney</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT ADDRESS <i>Mrs Mary Montgomery 506 N. Bruce St.</i>			

18. <i>154X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>CAUSE OF DEATH</i> <i>Carcinoma of rectum</i> DUE TO (A) _____ (B) <i>none</i> DUE TO (C) <i>none</i>	INTERVAL BETWEEN ONSET AND DEATH <i>6 mon.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>none</i>	

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

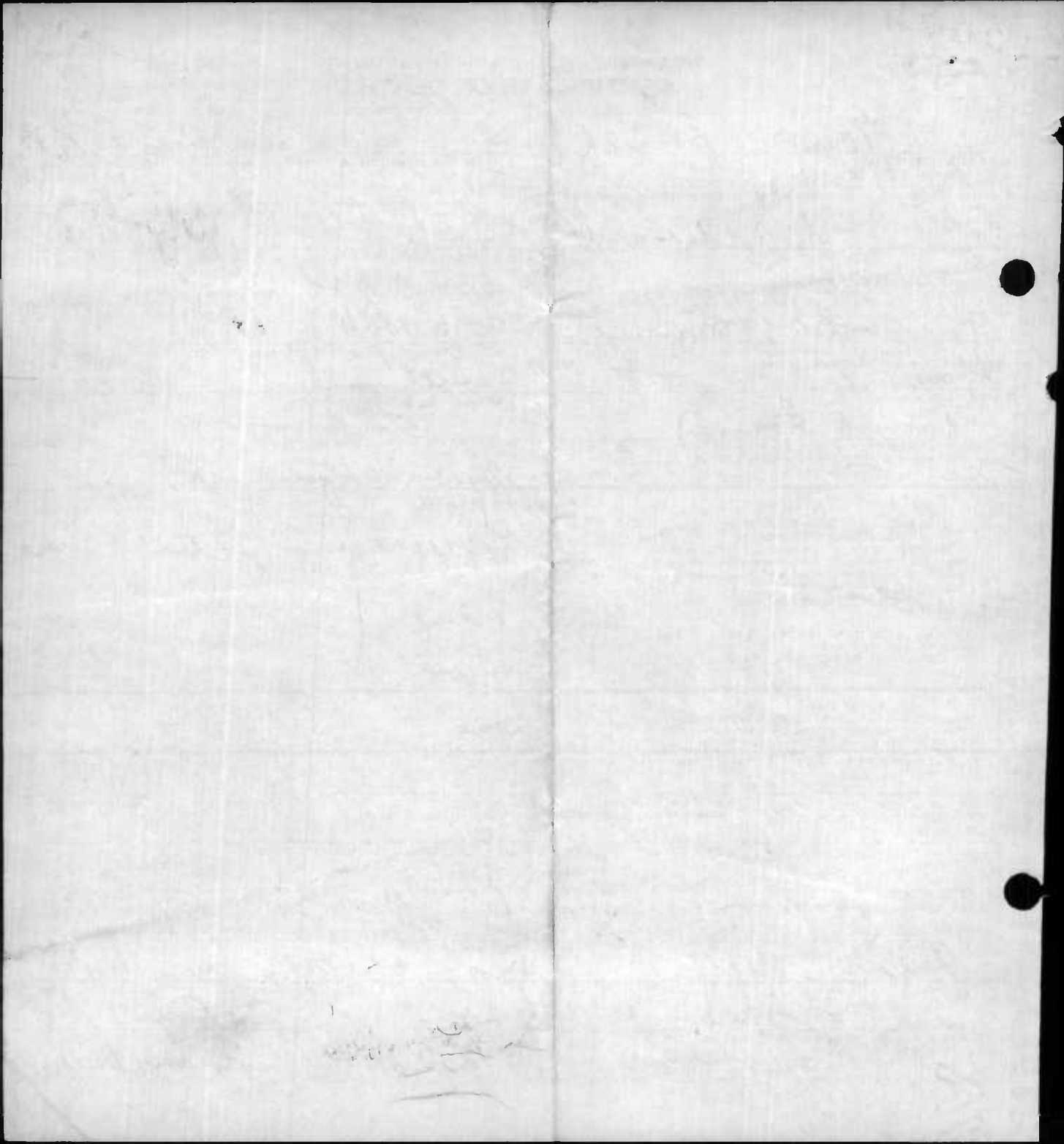
22. I hereby certify that I attended the deceased from *1/15*, *1950*, to *3/21*, *1950*, that I last saw the deceased alive on *3/20*, *1950*, and that death occurred at *7 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Benjamin Miller</i>	23B. ADDRESS <i>1030 W. Stokes Ave</i>	23C. DATE SIGNED <i>3/21/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/23/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>
24D. LOCATION (City, town, or county) (State) <i>Baile Md.</i>	25. FUNERAL DIRECTOR ADDRESS <i>Mildred E. Blight 6009 Harford Rd</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 22 1950</i>		REGISTRAR'S SIGNATURE <i>Hennington Williams</i>

467

MEDICAL CERTIFICATION  
Physicians: please write the causes of death clearly and legibly.







correct age is especially important. Physicians: please write the causes of death clearly and legibly. The cause of death should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Gertrude Johnson

2. DATE  
OF  
DEATH

March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

O. STREET ADDRESS (If rural, give location)

1500 Myrtle Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1500 Myrtle Ave.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

Dec. 25, 1874

9. AGE (In years last birthday)

75

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Jackson

14. MOTHER'S MAIDEN NAME

Mary Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Pauline Carter 1500 Myrtle Ave

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

6m.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Atherosclerosis

6m.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Senile Psychosis

3m.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 6, 1949 to Mar. 21, 1950 that I last saw the deceased alive on Mar. 21, 1950, and that death occurred at 8:40 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Franklin L. Lippert M.D.

1543 Penna. Ave.

3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3-23-50

Mt. Auburn

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

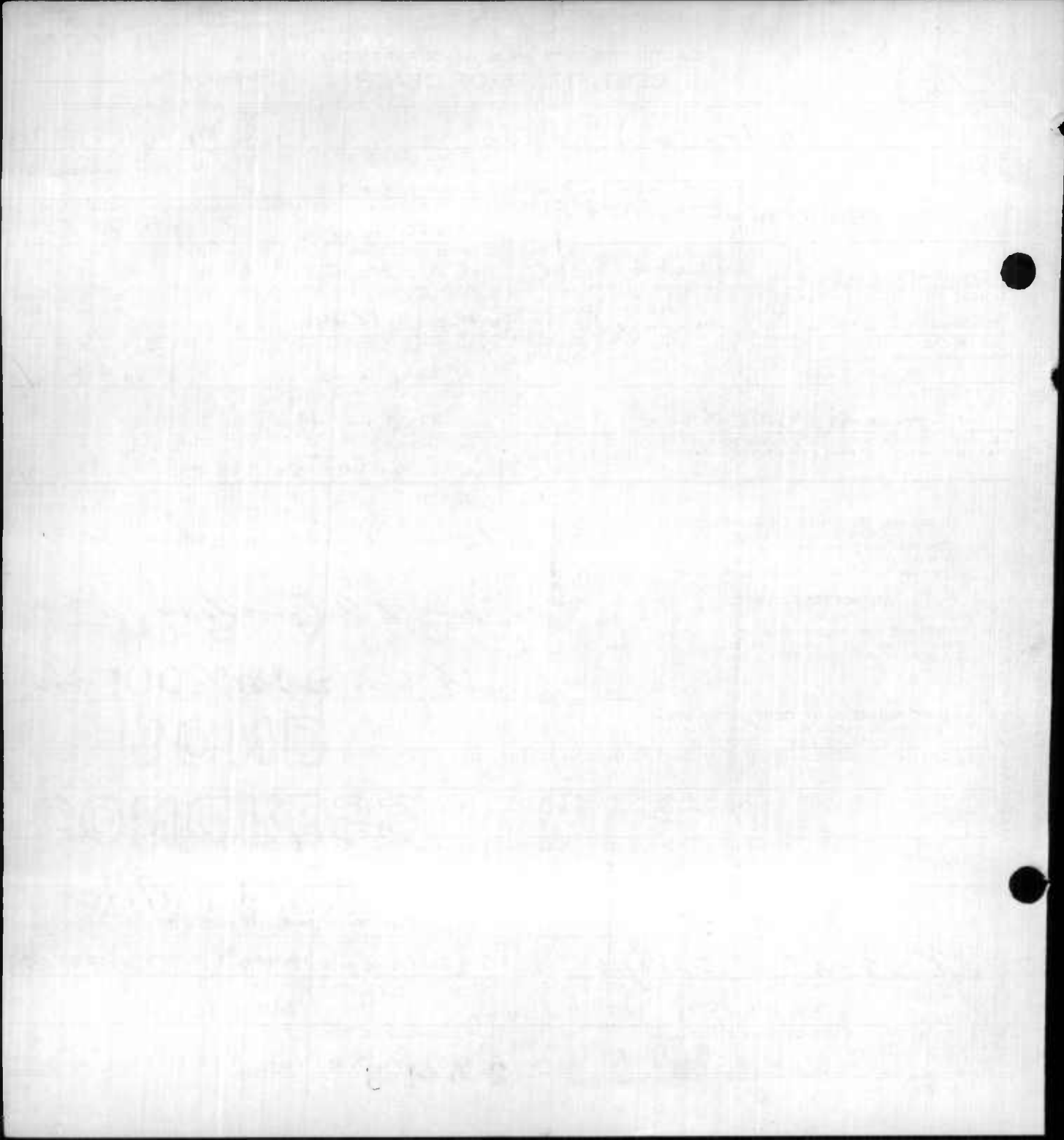
Geo. G. Kelson

1303 Presstman St

VS 150

937







correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 2642

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Matilda E. Pracht

2. DATE  
OF  
DEATH

March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

none

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Mrs. Lewis' Convalescent Home  
4203 Springdale Ave.

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
3710 Springdale Ave.

Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX  
female

6. COLOR OR RACE  
white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH

7-20-56

9. AGE (In years  
last birthday)

93

10 Under 1 Year Months Days  
11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U. S.

13. FATHER'S NAME

Charles Pracht

14. MOTHER'S MAIDEN NAME

Anna Mather

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS  
Miss Helen Pracht - 204 Cedarcroft Rd.

18. 491X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Bronchopneumonia  
general & cerebral  
sclerosis & senility

INTERVAL BETWEEN  
ONSET AND DEATH

10 days

? years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Mar., 1950, to 21 Mar., 1950, that I last saw the  
deceased alive on 21 Mar., 1950, and that death occurred at 8:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Louis E. Wice

23B. ADDRESS

M. D.

920 St. Paul St.

23C. DATE SIGNED

3 - 22 - 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
burial

24B. DATE

3 - 23 - 50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2643  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rebecca Matthews Coale

2. DATE OF DEATH  
March 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1811 Park Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Catonsville

D. STREET ADDRESS (If rural, give location)

Shady Nook Lane & Frederick Road

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH

Nov. 24, 1881

9. AGE (In years last birthday) If Under 1 Year Months Days If Under 24 Hours Hours Min.

68

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
registered nurse

10B. KIND OF BUSINESS OR INDUSTRY  
proprietress convalescent home

11. BIRTHPLACE (State or foreign country)

Chester County, Pa.

12. CITIZEN OF WHAT COUNTRY?  
U. S.

13. FATHER'S NAME

Lewis H. Coale

14. MOTHER'S MAIDEN NAME

Catherine Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Margaret M. Coale - 1811 Park Ave.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

10 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocarditis uncertain duration but chronic

DUE TO

(C) Moderate obesity

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1930, to March 20, 1950, that I last saw the deceased alive on March 20, 1950, and that death occurred at 1 P. M., from the causes and on the date stated above.

23A. SIGNATURE

E. H. Sawyer

23B. ADDRESS

13 E. Eager St.

23C. DATE SIGNED

3 - 21 - 50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
burial

24B. DATE

3 - 22 - 50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county) (State)

Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

ADDRESS

John A. Mitchell & Sons, Inc. - 1900 Eutaw Pl.

Dr. Hayward V3692

93D



# CERTIFICATE OF DEATH

1950

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important. Physicians: please write the causes of death clearly and legibly.

412

50 2644

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2644

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Nancy Lee Kaul Fuss</b>		2. DATE OF DEATH <b>3-21-1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>27-07</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>2819 CLEARVIEW AVE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
Length of stay in Baltimore Yrs. <b>6</b> Mos. <b>1</b> Days <b>2819 CLEARVIEW AVE</b>		D. STREET ADDRESS (If rural, give location)	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>April 12, 1927</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <b>JAMES KRUGER</b>		12. CITIZEN OF WHAT COUNTRY? <b>MD.</b>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>1</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Deahl</b>	
15. SOCIAL SECURITY NO. <b>216-22-4253</b>		17. INFORMANT <b>G. Edward Kaul Fuss 2819 Clearview</b>	
18. <b>410 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic Heart Disease</b> DUE TO ANTECEDENT CAUSES (over) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 1950</b> , to <b>Mar. 21, 1950</b> , that I last saw the deceased alive on <b>Mar. 21, 1950</b> , and that death occurred at <b>8:00 A. M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Nathan Janney</b>		23B. ADDRESS <b>7101 Harford Rd. 14</b>	
23C. DATE SIGNED <b>3/21/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-25-1950</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 22 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams</b>	
25. FUNERAL DIRECTOR <b>B. Howard Strong</b>		ADDRESS <b>3207 W. North A</b>	



See Document File 50-2644  
Report from query, in part:

"No fever at time of death.

Death due to cardiac decompensation  
as a result of mitral stenosis + insufficiency.  
Disease due to Rheumatic fever as per  
connections in etc "

4-19-50  
EO



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 2645

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CORA M. KELLY

2. DATE  
OF  
DEATH

3/20/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Virginia Lewis Nursing Home

60 4203 Springdale Avenue

Length of stay in Baltimore Unknown  
Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write R.R. and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

4203 Springdale Avenue

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

5/9/1869

9. AGE (In years last birthday)

80

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? Beckley

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No None

16. SOCIAL SECURITY NO.  
Unknown

17. INFORMANT

ADDRESS

Mrs. H. Mayhugh-115 S. East Ave.-Balto., Md.

18. 491X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Bronchopneumonia  
General & cerebral  
arteriosclerosis

1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

? years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1949 to 20 Mar. 1950, that I last saw the deceased alive on 20 Mar. 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Louis E. Wice

M. O.

23B. ADDRESS

920 St. Paul

23C. DATE SIGNED

22 Mar. 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/25/1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore County Md.

DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

MAR 22 1950

Wilmington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 403 S. Wolfe St. Balto. Md.



DR. MORRIS WATSON  
920 St. Paul Street  
Baltimore, Md.  
Ph. MULberry 0837

1:30 p.m.



Important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EUGENIA PEARL WILLIAMS

2. DATE

OF

DEATH

21 MARCH, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

CECELIA MCM. HEVENOR - DUNDALK

18. 541.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/19, 1950, to 3/21, 1950, that I last saw the deceased alive on 3/21, 1950, and that death occurred at 4:55 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 22 1950

Christington Williams, Jr.

13411 Biddle Blvd, Dundalk, Md.







CERTIFICATE CORRECTED 4-12-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 2647

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ISAAC DAVIS

2. DATE  
OF  
DEATH

3/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3503 Reisterstown Road

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widower

Yrs.  
Mos.  
Days

Length of stay in Baltimore

35 Yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shoe Repairing

10B. KIND OF BUSINESS OR INDUSTRY

Own Business

8. DATE OF BIRTH

1890, 1891

9. AGE (In years last birthday)

60-59

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Morris Davis

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Bernard Davis 5101 Nelson Ave

18. 159X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) ASHD - Failure

DUE TO

Probable S.I. Malignancy

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 12/29, 1950, to 3/22, 1950, that I last saw the deceased alive on 3/22, 1950, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Leonard Kot

23B. ADDRESS

Sinai Hosp

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Rosedale Cem

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

MAR 22 1950

REGISTRAR'S SIGNATURE

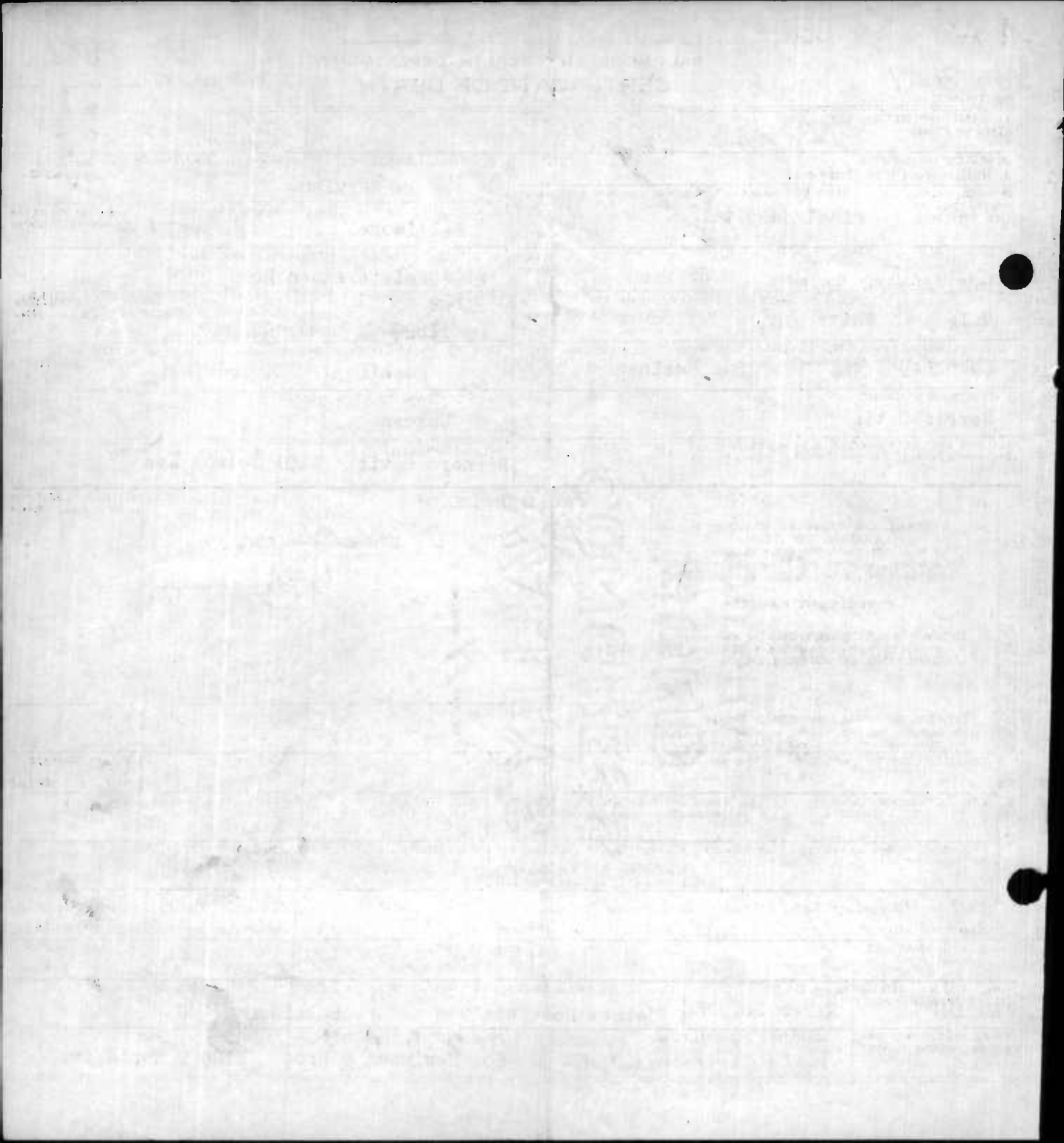
Wilmington Williams, MD

25. FUNERAL DIRECTOR

Sol Lewinson & Bros 1126 W North Ave

ADDRESS







PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

163

50 2648

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2648

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ANNA K. EVERD

2. DATE  
OF  
DEATH

MAR 21 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

6. STREET ADDRESS (If rural, give location)

6. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WORK

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Kuhn

14. MOTHER'S MAIDEN NAME

Isabelle Dolan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 410. X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Myocardial insufficiency  
post-operative  
(B) Rheumatic heart disease -  
with mitral stenosis and  
insufficiency  
(C)

INTERVAL BETWEEN ONSET AND DEATH

20 hrs.

15 yrs.

19A. DATE OF OPERATION

3/20/50

19B. MAJOR FINDINGS OF OPERATION

Mitral stenosis

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-13-1950 to 3-21-1950 that I last saw the deceased alive on 3-21-1950 and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard L. Kipper, Jr. M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

3-24-50

24C. NAME OF CEMETERY OR CREMATORY

GLEN HAVEN MEM. CEM. RITCHIE HIGHWAY, MD.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 22 1950

REGISTRAR'S SIGNATURE

William Kuhn

25. FUNERAL DIRECTOR

Charles J. Giler, 901 S. Conkling St.

ADDRESS



STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

BIRTHPLACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

W. H. L. 11

Signature of Registrar

Signature of Deceased

Signature of Witness

Signature of Minister

Signature of Coroner

Signature of Jury

Signature of Judge

Signature of Clerk

Signature of Sheriff

Signature of Constable

Signature of Justice

Signature of Notary

Signature of Assessor

Signature of Collector

Signature of Treasurer

Signature of Comptroller

Signature of Attorney



500  
50 2649

50 2649

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

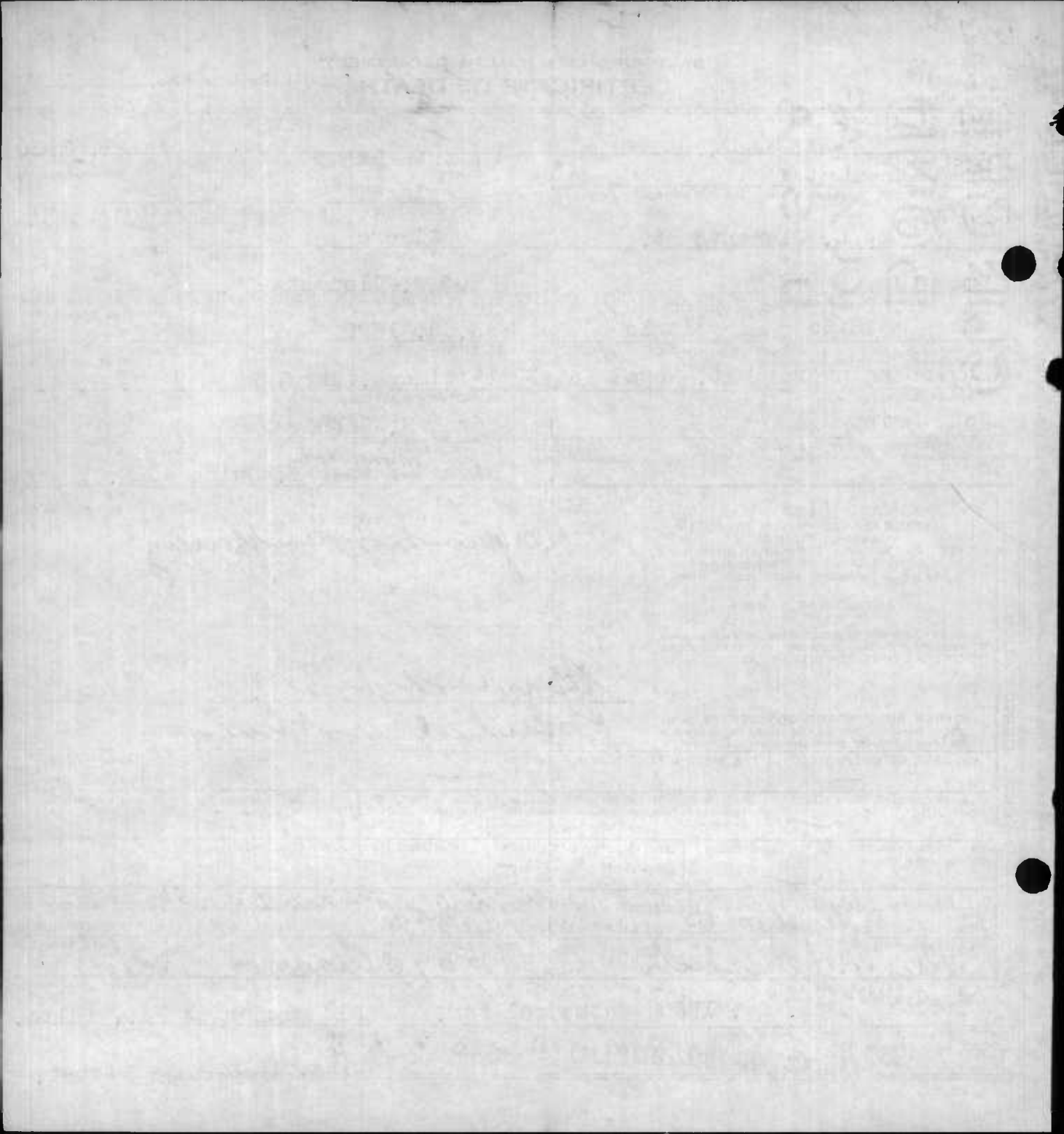
Registered No. \_\_\_\_\_

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>FRANCIS P. QUINN</b>			2. DATE OF DEATH <b>March 21, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> (If outside corporate limits, write RURAL, and give township) <b>24-02</b>			D. STREET ADDRESS (If rural, give location) <b>406 E. Clements St.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>406 E. Clements St.</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
C. Length of stay in Baltimore			7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>			8. DATE OF BIRTH <b>Feb. 5, 1895</b>		
9. AGE (In years, last birthday) <b>55</b>			10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Engineer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Mt. Royal Hotel</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>John Quinn</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah H. Cooney</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Miss Margaret M. Quinn</b>			ADDRESS <b>406 E. Clements St.</b>			18. <b>422.2</b>		
CAUSE OF DEATH			DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) <b>Myocardial Insufficiency</b>		
ANTECEDENT CAUSES			DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) <b>Myocarditis &amp; Bronchial Asthma</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I hereby certify that I attended the deceased from <b>March 10, 1950</b> , to <b>March 21, 1950</b> , that I last saw the deceased alive on <b>March 20, 1950</b> , and that death occurred at <b>3:45 p.m.</b> , from the causes and on the date stated above.			23A. SIGNATURE <b>John G. Scheuch</b>		
23B. ADDRESS <b>1234 S. Charles St.</b>			23C. DATE SIGNED <b>3/22/50</b>			24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>Mar. 24, 1950</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Old Frederick Rd., Balto.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 22 1950</b>			REGISTRAR'S SIGNATURE <b>Huntington Williams</b>			25. FUNERAL DIRECTOR <b>Flynn &amp; Fleming</b>		
ADDRESS <b>1426 Light Street.</b>			35687			93E		

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







correct age is especially important. Physicians: please write the causes of death clearly and legibly. If the cause of death is not known, it should be so stated. If the cause of death is not known, it should be so stated. If the cause of death is not known, it should be so stated.

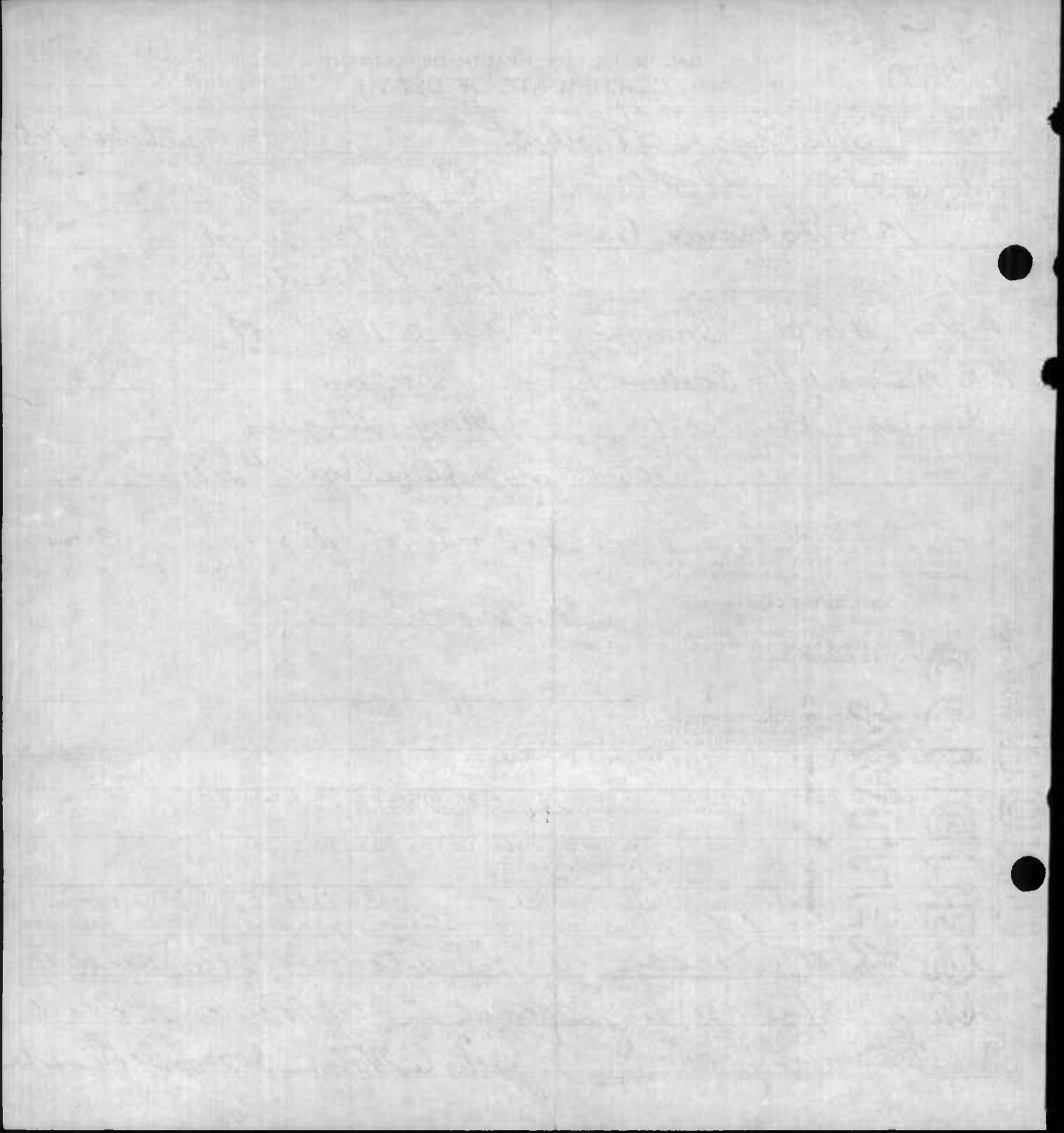
452  
50 2650

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2650  
Registered No. \_\_\_\_\_

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <i>Joseph Higgins Plunkett</i>			2. DATE OF DEATH <i>March 20, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Maryland</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i>			C. CITY OR TOWN <i>Maryland</i> (If outside corporate limits, write R.F.D. and give township)		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1205 Lakeside Cre</i>			D. STREET ADDRESS (If rural, give location) <i>1205 Lakeside Cre</i>			E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>March 15 1861</i>		9. AGE (In years last birthday) <i>89</i>	10. UNDER 1 Year Months Days		11. UNDER 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R.R. Passenger Office</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Railroad. Retired</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>James Plunkett</i>			14. MOTHER'S MAIDEN NAME <i>Mary Higgins</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>705-05-269</i>			17. INFORMANT <i>Josephine Pryer</i>		
18. <i>442 X</i>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) <i>Cardio-Renal Disease</i>			<i>3 mos.</i>		
DUE TO			(B) <i>Atherosclerosis</i>			DUE TO		
DUE TO			(C)			DUE TO		
DUE TO			(D)			DUE TO		
DUE TO			(E)			DUE TO		
DUE TO			(F)			DUE TO		
DUE TO			(G)			DUE TO		
DUE TO			(H)			DUE TO		
DUE TO			(I)			DUE TO		
DUE TO			(J)			DUE TO		
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DUE TO			(M)			DUE TO		
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DUE TO			(P)			DUE TO		
DUE TO			(Q)			DUE TO		
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DUE TO			(T)			DUE TO		
DUE TO			(U)			DUE TO		
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DUE TO			(BG)			DUE TO		
DUE TO			(BH)			DUE TO		
DUE TO			(BI)			DUE TO		
DUE TO			(BJ)			DUE TO		
DUE TO			(BK)			DUE TO		
DUE TO			(BL)			DUE TO		
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DUE TO			(BN)			DUE TO		
DUE TO			(BO)			DUE TO		
DUE TO			(BP)			DUE TO		
DUE TO			(BQ)			DUE TO		
DUE TO			(BR)			DUE TO		
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DUE TO			(BX)			DUE TO		
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DUE TO			(BZ)			DUE TO		
DUE TO			(CA)			DUE TO		
DUE TO			(CB)			DUE TO		
DUE TO			(CC)			DUE TO		
DUE TO			(CD)			DUE TO		
DUE TO			(CE)			DUE TO		
DUE TO			(CF)			DUE TO		
DUE TO			(CG)			DUE TO		
DUE TO			(CH)			DUE TO		
DUE TO			(CI)			DUE TO		
DUE TO			(CJ)			DUE TO		
DUE TO			(CK)			DUE TO		
DUE TO			(CL)			DUE TO		
DUE TO			(CM)			DUE TO		
DUE TO			(CN)			DUE TO		
DUE TO			(CO)			DUE TO		
DUE TO			(CP)			DUE TO		
DUE TO			(CQ)			DUE TO		
DUE TO			(CR)			DUE TO		
DUE TO			(CS)			DUE TO		
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DUE TO			(CV)			DUE TO		
DUE TO			(CW)			DUE TO		
DUE TO			(CX)			DUE TO		
DUE TO			(CY)			DUE TO		
DUE TO			(CZ)			DUE TO		
DUE TO			(DA)			DUE TO		
DUE TO			(DB)			DUE TO		
DUE TO			(DC)			DUE TO		
DUE TO			(DD)			DUE TO		
DUE TO			(DE)			DUE TO		
DUE TO			(DF)			DUE TO		
DUE TO			(DG)			DUE TO		
DUE TO			(DH)			DUE TO		
DUE TO			(DI)			DUE TO		
DUE TO			(DJ)			DUE TO		
DUE TO			(DK)			DUE TO		
DUE TO			(DL)			DUE TO		
DUE TO			(DM)			DUE TO		
DUE TO			(DN)			DUE TO		
DUE TO			(DO)			DUE TO		
DUE TO			(DP)			DUE TO		
DUE TO			(DQ)			DUE TO		
DUE TO			(DR)			DUE TO		
DUE TO			(DS)			DUE TO		
DUE TO			(DT)			DUE TO		
DUE TO			(DU)			DUE TO		
DUE TO			(DV)			DUE TO		
DUE TO			(DW)			DUE TO		
DUE TO			(DX)			DUE TO		
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DUE TO			(DZ)			DUE TO		
DUE TO			(EA)			DUE TO		
DUE TO			(EB)			DUE TO		
DUE TO			(EC)			DUE TO		
DUE TO			(ED)			DUE TO		
DUE TO			(EE)			DUE TO		
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DUE TO			(EG)			DUE TO		
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DUE TO			(LG)			DUE TO		
DUE TO			(LH)			DUE TO		
DUE TO			(LI)			DUE TO		
DUE TO								







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2651

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MC FADDEN, Charles

2. DATE  
OF  
DEATH

3/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Provident

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

East. Md.

D. STREET ADDRESS (If rural, give location)

106 Warner St

WARNER ST

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

Negro

7. SINGLE MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct. 14, 1916

9. AGE (In years  
last birthday)

34

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Alcohu, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Mc Fadden

14. MOTHER'S MAIDEN NAME

Hester Stog.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Clara Mc Fadden, 906 Warner St

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Renal Insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Chronic Glomerulonephritis

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 3/20, 1950, to 3/21, 1950, that I last saw the  
deceased alive on 3/21, 1950, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE

John H. Holmes III

M. D.

23B. ADDRESS

Provident Hosp

23C. DATE SIGNED

3/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3-25-1950

24C. NAME OF CEMETERY OR CREMATORY

Greenhill Cemetery

24D. LOCATION (City, town, or county)

Summers

(State)

S.C.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 22 1950

REGISTRAR'S SIGNATURE

Livingston Williams, M.D.

25. FUNERAL DIRECTOR

Mr. Walter R. Williams

ADDRESS

322 N. Schrock St



hi

2039



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

5-363  
50 2652

50 2652

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) John B. Sturdevant 2. DATE OF DEATH MARCH 22 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION Good SAMARITAN Home 29 N. Carey St. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02

D. STREET ADDRESS (If rural, give location) 29 N. Carey St. Yrs. Mos. Days

5. SEX male 6. COLOR OR RACE white 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) \_\_\_\_\_ 8. DATE OF BIRTH about 1899 9. AGE (In years last birthday) about 51 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman SOLICITOR 10B. KIND OF BUSINESS OR INDUSTRY aluminum (RETAIL) 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13. FATHER'S NAME Calvin Sturdevant 14. MOTHER'S MAIDEN NAME Florence Bingaman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. 216-09-3420 17. INFORMANT ADDRESS M. L. Creager & Son Thurmont, Md.

18. 331X I CAUSE OF DEATH (A) Cerebra hemorrhage (B) Right hemiplegia (C) Aphonia DUE TO \_\_\_\_\_ DUE TO \_\_\_\_\_ DUE TO \_\_\_\_\_ DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_ 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from March 1, 1950, to March 22, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 7.20 A m., from the causes and on the date stated above.

23A. SIGNATURE Melvin H. Borden M. D. 23B. ADDRESS 2030 W. Fayette St 23C. DATE SIGNED 3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/24/50 24C. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cem. 24D. LOCATION (City, town, or county) (State) Foxville, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 24 1950 REGISTRAR'S SIGNATURE Thurmont, Md. 25. FUNERAL DIRECTOR ADDRESS 2 M. L. Creager & Son Thurmont, Md.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

PLACE OF ENTRY INTO STATE

DATE OF DEPARTURE FROM STATE

PLACE OF DEPARTURE FROM STATE

DATE OF RETURN TO STATE

PLACE OF RETURN TO STATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH



correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

530  
50 2653

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2653  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

IDA V. SMITH

2. DATE  
OF  
DEATH

March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

751 W. Baltimore St.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

751 W. Baltimore St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Jan. 19, 1868

9. AGE (In years,  
last birthday)

81

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Watts

14. MOTHER'S MAIDEN NAME

Katherine -

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Howard Smith - 2545 Kirk Ave.

18. *4221*  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

1 da

5 hr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT ☐ WORK  
NOT WHILE ☐ AT WORK

22. I hereby certify that I attended the deceased from *3/21*, 19*50*, to *3/21*, 19*50*, that I last saw the  
deceased alive on *3/21*, 19*50*, and that death occurred at *7:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Joseph L. Lukaitis*

M. D.

23B. ADDRESS

*6754 Washington Blvd*

23C. DATE SIGNED

*3/22/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/24/50

24C. NAME OF CEMETERY OR CREMATORY

Ivy Hill

24D. LOCATION (City, town, or county)

Laurel, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 22 1950

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

2 WM. E. TUCKNER & SONS

ADDRESS

Balto., Md.







PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2654

Registered No. \_\_\_\_\_

BIRTH NO. 50 2654

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
ORRIN W. WALTERMYER		3/22/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE	
1623 Linden Ave		Md	
C. Length of stay in Baltimore		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Yrs. Mos. Days		Balto Md 14-01	
5. SEX		D. STREET ADDRESS (If rural, give location)	
M		1623 Linden Ave	
6. COLOR OR RACE		8. DATE OF BIRTH	
W		March 7, 1881	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		9. AGE (In years last birthday)	
Married		69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Plumber		Stewartstown, Pa.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Furnace (M)			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
no		216-20-4703	
17. INFORMANT		ADDRESS	
Mrs. Alexandria Waltemyer		1623 Linden Ave	

18. 4 yr. 1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Antecedent causes			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
0				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		23A. SIGNATURE		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	
C. S. Sulinski		M.D.		23C. DATE SIGNED 3/22/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3/24/50		Balto. National Cem. Balto., Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
MAR 22 1950		Huntington		W. G. PICKNER & SONS	
				ADDRESS	
				Balto., Md.	

VS 151

34830

930







94a



CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

11. Signature of witness

12. Signature of informant

13. Signature of funeral director

14. Signature of undertaker

15. Signature of cemetery

16. Signature of church

17. Signature of school

18. Signature of hospital

19. Signature of prison

20. Signature of other

21. Signature of other

22. Signature of other

23. Signature of other

24. Signature of other

25. Signature of other

26. Signature of other

27. Signature of other

28. Signature of other

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109. Signature of other

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111. Signature of other

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117. Signature of other

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121. Signature of other

122. Signature of other

123. Signature of other

124. Signature of other

125. Signature of other

126. Signature of other

127. Signature of other

128. Signature of other

129. Signature of other

130. Signature of other

131. Signature of other

132. Signature of other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

-620

50 2656

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2656

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Mr. Lillian Search</i>			2. DATE OF DEATH <i>3/24/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Md.</i>			C. CITY OR TOWN (If outside corporate limits write RURAL, and give township) <i>Balto</i>		
D. STREET ADDRESS (If rural, give location) <i>1837 Bolton St.</i>			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8/10/1871</i>	9. AGE (In years last birthday) <i>78</i>	10. UNDER 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>			12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME <i>John W. Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Sophia L. Callett</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <i>W. H. Search Jr.</i>			ADDRESS <i>1837 Bolton St.</i>		

18. <i>199.8</i>   <i>154X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Carcinoma - Generalized</i> DUE TO (B) <i>(primary site: recto-sigmoid)</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH _____
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19A. DATE OF OPERATION <i>3/24/50</i>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>3/1/50</i> , 19 <i>50</i> , to <i>3/24/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/21</i> , 1950, and that death occurred at <i>3:30</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Lillian Search</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>3/24/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/24/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>		24E. STATE <i>Md.</i>		25. FUNERAL DIRECTOR <i>Wm. Cook Inc.</i>	
25A. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		25B. REGISTRAR'S SIGNATURE <i>Wm. Cook</i>		25C. ADDRESS <i>1217 St. Paul St.</i>	

46D



See Document File 50-2656

4-19-50

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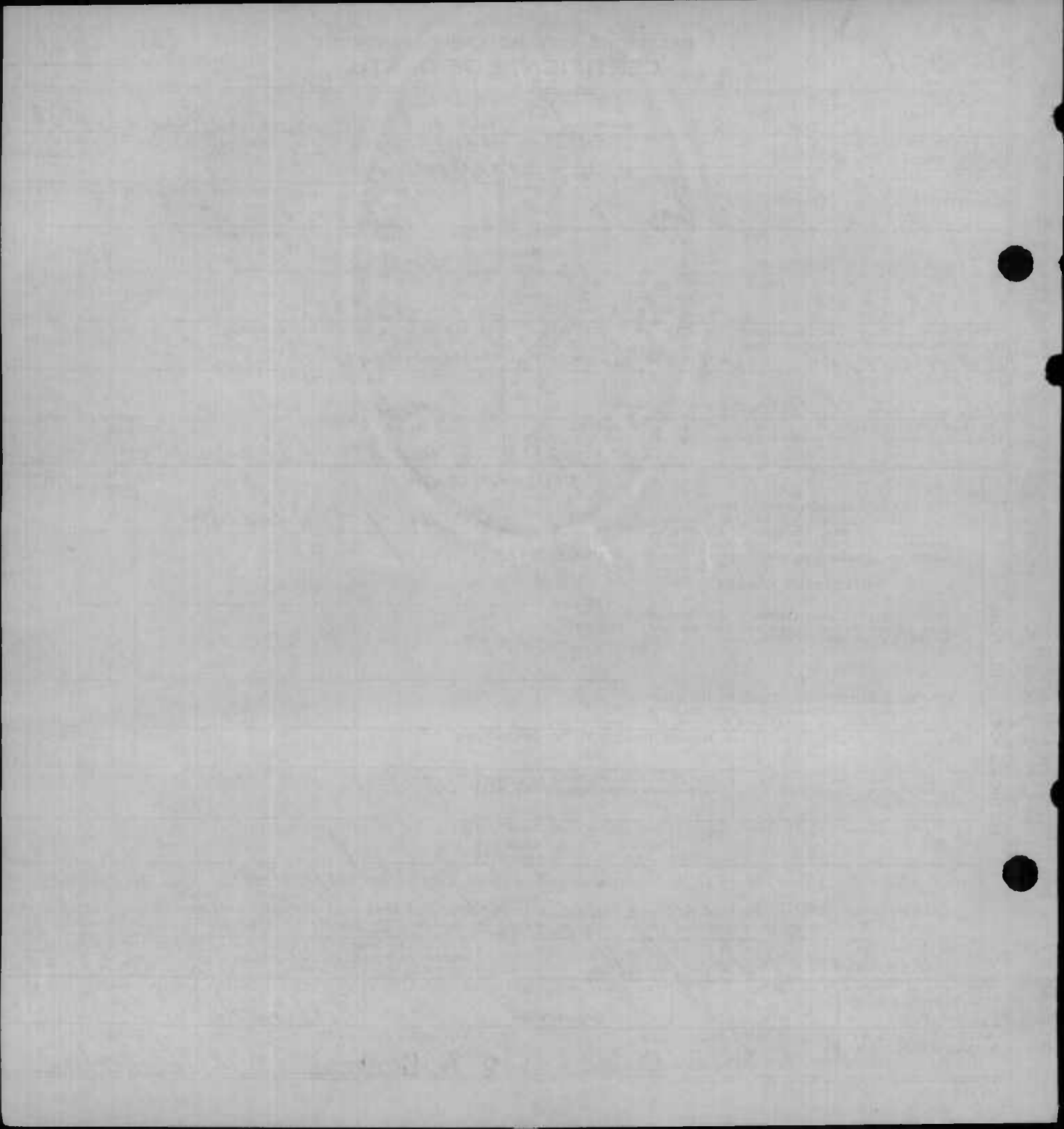
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2657  
Registered No. 50 2657

BIRTH NO. 50 2657	
1. NAME OF DECEASED (Type or Print) <i>Joshua E. Bowers</i>	
2. DATE OF DEATH <i>March 22, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>5205 St Charles Ave</i>	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
O. STREET ADDRESS (If rural, give location) <i>5205 St Charles Ave</i>	
c. Length of stay in Baltimore	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec 15, 1878</i>
9. AGE (In years last birthday) <i>71</i>	10. UNDER 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hard Foreman</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>Coal &amp; Fuel (R)</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Lease L Bowers</i>	14. MOTHER'S MAIDEN NAME <i>Emily J Upton</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>W</i>	16. SOCIAL SECURITY NO. <i>217-01-0232</i>
17. INFORMANT ADDRESS <i>Mary M Bowers, 5205 St Charles Ave</i>	
18. <i>420.1</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary occlusion.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, <i>Inspection</i> or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .	
23A. SIGNATURE <i>William J. Helfrich</i>	
23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	
23C. DATE SIGNED <i>3-22-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>	
24B. DATE <i>3/25/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>	
REGISTRAR'S SIGNATURE <i>William J. Helfrich</i>	
25. FUNERAL DIRECTOR <i>W. J. Helfrich</i>	
ADDRESS <i>1277 E. Paul St</i>	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

550  
50 2658

BAUMANN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2658  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillian Baumann

2. DATE  
OF  
DEATH

March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

Washington

C. CITY OR TOWN

Camp Ritchie Hospital

D. STREET ADDRESS (If rural, give location)

7100

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3-5-87

9. AGE (In years  
last birthday)

63

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank Smith

14. MOTHER'S MAIDEN NAME

Katherine Gayhardt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 260 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pulmonary embolism, acute

3 1/2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Diabetic gangrene, lt foot  
Supercardylar angustation fob

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Myocardial infarction

19A. DATE OF OPERATION

3-19-50

19B. MAJOR FINDINGS OF OPERATION

Diabetic gangrene, lt foot

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., at or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

ml. WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

James B. Moore, M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3-21-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3-24-50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county) (State)

Baltimore City

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

2503 Edmondson

2503 Edmondson



STATE OF TEXAS  
COUNTY OF BROWN

WITNESSES  
J. A. S. & C. A. S.



Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

M-244

50 2659

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2659

Registered No.

BIRTH NO. 50-06620

1. NAME OF DECEASED  
(Type or Print)

BABY BOY McCLELLAN

2. DATE OF DEATH

3-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

Bon SECOURS Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

3/21/50

9. AGE (In years last birthday)

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

MR. George McCLELLAN

14. MOTHER'S MAIDEN NAME

Allynn Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Dr. B. McClellan

ADDRESS

944 Rose Dale St.

18. 776X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 hr. 10 min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

0

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 20, 1950, to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 2:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Paul S. Marino

M. D.

23B. ADDRESS

Bon Secours Hospital

23C. DATE SIGNED

3/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

3-23-50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Howard

(State)

Geo. McP

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

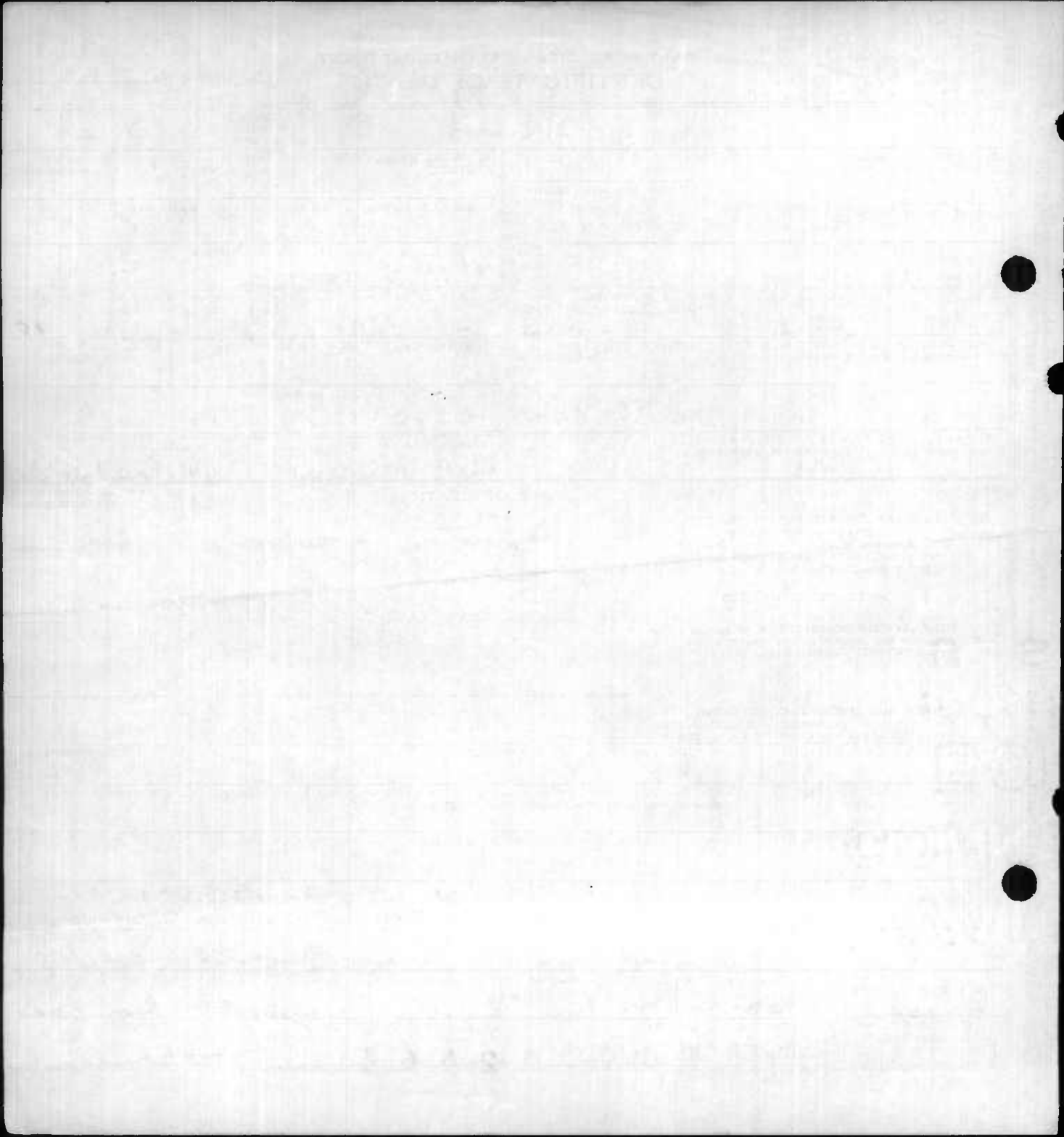
Huntington, W. Va.

2503 Edmondson Ave

VS 150

159







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2660

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOHN EDWARDS</b>			2. DATE OF DEATH <b>March 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>414 Orchard Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>7/10/1870</b>	9. AGE (In years last birthday) <b>79</b>	10. Under 1 Year Months _____ Days _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor, Man</b>			11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Jesse Edwards</b>			ADDRESS <b>122 N. Schroeder St.</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardio-vascular disease</b>	CAUSE OF DEATH (A) <b>Hypertensive Cardio-vascular disease</b> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

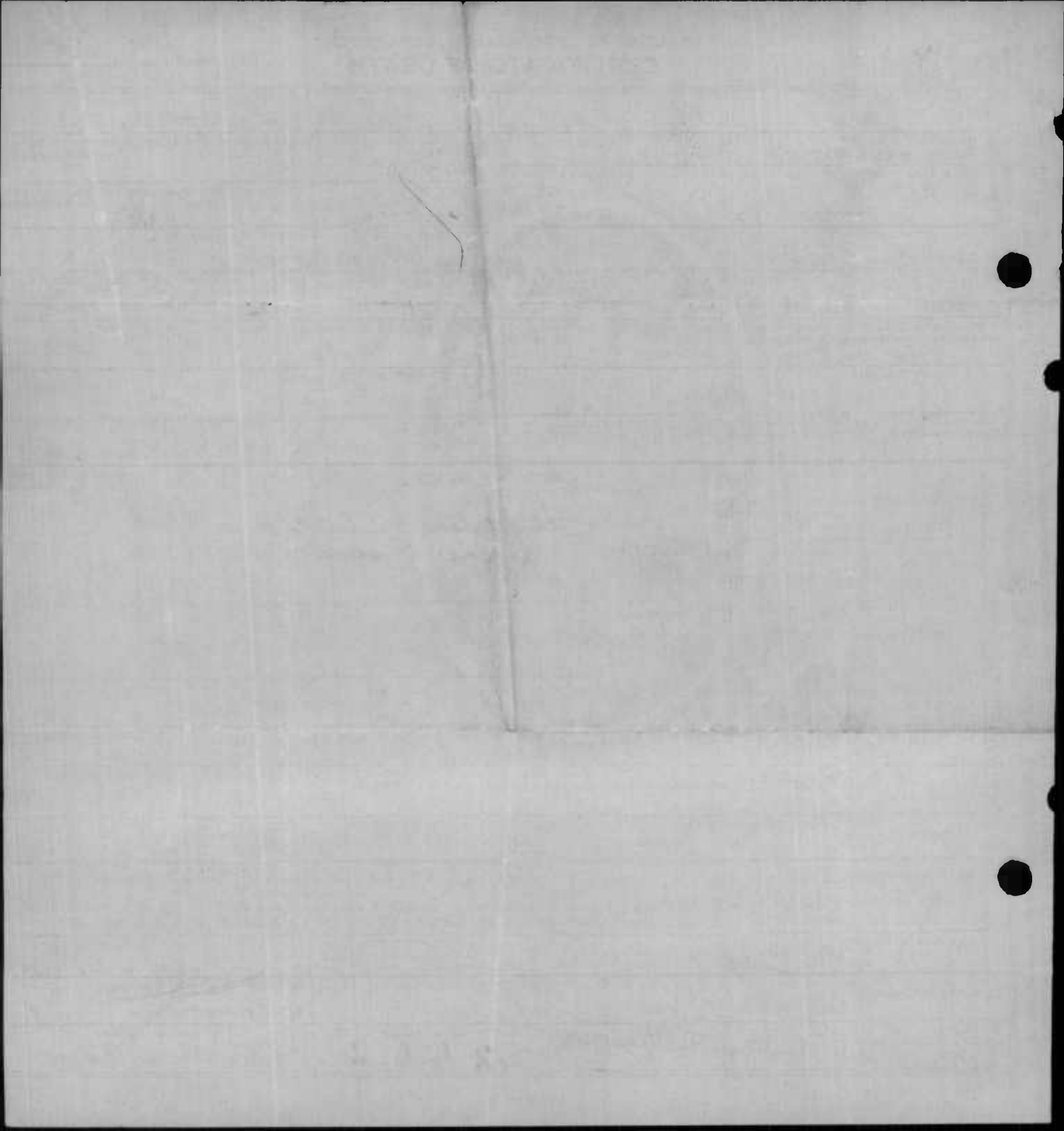
22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE <b>Dr. J. McClafferty</b>	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>March 21, 1950</b>
---	---	---

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>3/25/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
---	-----------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 23 1950</b>	REGISTRAR'S SIGNATURE <b>W. J. Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Charles A. Rice</b>	ADDRESS <b>661 W. Bore</b>
--	--	--	-------------------------------







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and possibly.

AB-136196

50 2661

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2661

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Jones

2. DATE  
OF  
DEATH

3-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1016 Appleton St.

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

N

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 12-1881

9. AGE (In years;  
last birthday)

68

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PORTER

10B. KIND OF BUSINESS OR  
INDUSTRY

DEPT. STORE

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

William

14. MOTHER'S MAIDEN NAME

Annie Dutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

215-09-9918

17. INFORMANT  
Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Metastatic Tumor of Brain

(C) Bronchiogenic Carcinoma

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-28-1950, to 3-20-1950 that I last saw the  
deceased alive on 3-20-1950 and that death occurred at 11.40AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

3-20-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

William Jones

Joseph A. Lirich 661 W. Bane St

VS 150

750 63

47c



CERTIFICATE OF DEATH

State of New York  
County of New York  
City of New York

I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, New York, I attended \_\_\_\_\_, who died of \_\_\_\_\_.

Witness my hand and the seal of my office, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Attending Physician

\_\_\_\_\_  
Medical Examiner

\_\_\_\_\_  
Coroner

\_\_\_\_\_  
Registrar

\_\_\_\_\_  
Witness



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2662

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SAMUEL BESSER

2. DATE  
OF  
DEATH

3-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

2522 Oakley Ave

C. CITY OR TOWN

(If outside corporate limits, write PURA, and give township)

D. STREET ADDRESS (If rural, give location)

2522 Oakley Ave

6. Length of stay in Baltimore

32

Yrs.

Mos.

Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

43

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cleric

10B. KIND OF BUSINESS OR  
INDUSTRY

Western Union

11. BIRTHPLACE (State or foreign country)

Richmond Va

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David

14. MOTHER'S MAIDEN NAME

Eva

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Eva Besser 2522 Oakley Ave

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Bronchopneumonia (terminal)

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Carcinoma of the breast with  
metastases

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Jan. 1950

19B. MAJOR FINDINGS OF OPERATION

CH of the breast - metastases

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 10, 1950, to March 22, 1950, that I last saw the deceased alive on 3/22, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Louis R. Wason

M. D.

23B. ADDRESS

4335 Park Heights

23C. DATE SIGNED

3/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3-23-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Mt Carmel

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 23 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis, Inc.

ADDRESS

2100 Eastland Pl

VS 150

26656

46E



Maseru  
4535 Park Hgts  
70 6759

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2663  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Zacharski, Miss Anna</i>		2. DATE OF DEATH <i>3-21-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home &amp; Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write "U.S.A." and give zip) <i>Baltimore 31302</i>	
C. Length of stay in Baltimore <i>yes</i>		D. STREET ADDRESS (If rural, give location) <i>1511 Lancaster St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3-4-1893</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE (In years, last birthday) <i>57</i>
13. FATHER'S NAME <i>Zacharski, Andrew</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Anna Mary Kozlowski</i>	
17. INFORMANT <i>Rel.</i>		ADDRESS	

MEDICAL CERTIFICATION

18. <i>561.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Intestinal Obstruction 7 days</i> DUE TO (B) <i>Hemoral Hernia, strangulation of.</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>3-21-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Intestinal obstruction</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>March 21, 1950</i> to <i>March 24, 1950</i> , that I last saw the deceased alive on <i>March 24, 1950</i> , and that death occurred at <i>9 P. M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Ronald Keaton</i>	23B. ADDRESS <i>Church Home &amp; Hosp.</i>	23C. DATE SIGNED <i>3-21-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Mar 24-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St Stanislaus</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	25. FUNERAL DIRECTOR <i>George A Weber</i>	ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

100

100

100

100

100



correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-300  
50 2664

50 2664

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>George W. Reed</i>		2. DATE OF DEATH <i>Mar 21/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1307 N. Milton Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i> Md. </i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 8-03</i>	
Length of stay in Baltimore <i>60 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>1307 N. Milton Ave</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Mar 31/1871</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>	9. AGE (In years: last birthday) <i>78</i> If Under 1 Year Months: <i>11</i> Days: <i>21</i> If Under 24 Hours Hours: _____ Min. _____
11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>Aubray Reed</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Upton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Paul Reed Jr.</i>		ADDRESS <i>3104 E. Federal St.</i>	

MEDICAL CERTIFICATION

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i> DUE TO (A) _____	CAUSE OF DEATH <i>Coronary Thrombosis</i>	INTERVAL BETWEEN ONSET AND DEATH _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>1. Hypertension + myocarditis</i> DUE TO (B) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____	(C) _____	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>June</i> , 19 <i>49</i> to <i>5</i> <i>Mar</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3</i> , 19 <i>50</i> , and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Harry Quibert</i>		23B. ADDRESS <i>6006 Eastern Ave</i>		23C. DATE SIGNED <i>3/22/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
25. FUNERAL DIRECTOR <i>Philip H. Burg Sons</i>		ADDRESS <i>2024 Orleans St</i>			



Gilbert

6006 Eastern Ave

MAILED  
JUN 10 1964  
U.S. AIR MAIL  
100



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

300  
50 2665

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2665

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) Ellis C. Hewitt

2. DATE OF DEATH March 22, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE md. B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write R.U.M. and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
2821 Matthews St

E. Length of stay in Baltimore 47 Yrs. Mos. Days

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH 9-16-89

9. AGE (In years last birthday) 60 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
invalid LABORER

10B. KIND OF BUSINESS OR INDUSTRY  
odd jobs

11. BIRTHPLACE (State or foreign country)  
Williamsport Washington County, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.

13. FATHER'S NAME  
Edward C. Hewitt

14. MOTHER'S MAIDEN NAME  
Sarah V. Russler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT JOHNS HOPKINS HOSPITAL

ADDRESS \_\_\_\_\_

18. 470.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

25 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Macrocytic Anemia, C/V.

6 yrs

19A. DATE OF OPERATION 2

19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from April 10, 1948 to March 22, 1950, that I last saw the deceased alive on March 20, 1950, and that death occurred at 44 m., from the causes and on the date stated above.

23A. SIGNATURE Robert C. Hartmann M.D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3-24-50

24C. NAME OF CEMETERY OR CREMATORY Green Hill

24D. LOCATION (City, town, or county) Martinsburg, W. Va.

State \_\_\_\_\_

DATE RECEIVED BY LOCAL REGISTRAR MAR 25 1950

REGISTRAR'S SIGNATURE Huntington Williams

25. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc.

ADDRESS 1900 Eutaw Pl.

VS 150

98899

W.B. Mitchell 937



Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
Date of Certificate		Time of Certificate		Place of Certificate		Signature of Registrar		Signature of Witness		Signature of Deceased	



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2666

50 2666

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LILIAN ESTELLE MAHOOD

2. DATE  
OF  
DEATH

March 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3803 Callaway Avenue

Length of stay in Baltimore

5 months

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

School Teacher

10B. KIND OF BUSINESS OR  
INDUSTRY

Virginia School System

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. George Bassett 3803 Callaway Ave.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic cardio-vascular  
disease

10 years

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Oct 26, 1949

19B. MAJOR FINDINGS OF OPERATION

Generalized Arteriosclerosis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 16, 1949, to March 22, 1950, that I last saw the  
deceased alive on March 22, 1950, and that death occurred at 8:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Millard T. Trarand Jr.

M. D.

23B. ADDRESS

3408 Woodbine Ave. Balt., Md.

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

3/23/50

24C. NAME OF CEMETERY OR CREMATORY

-

24D. LOCATION (City, town, or county)

Lynchburg, Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William O. Williams

25. FUNERAL DIRECTOR

ADDRESS

M. G. GICKER & SONS

Balto., Md.

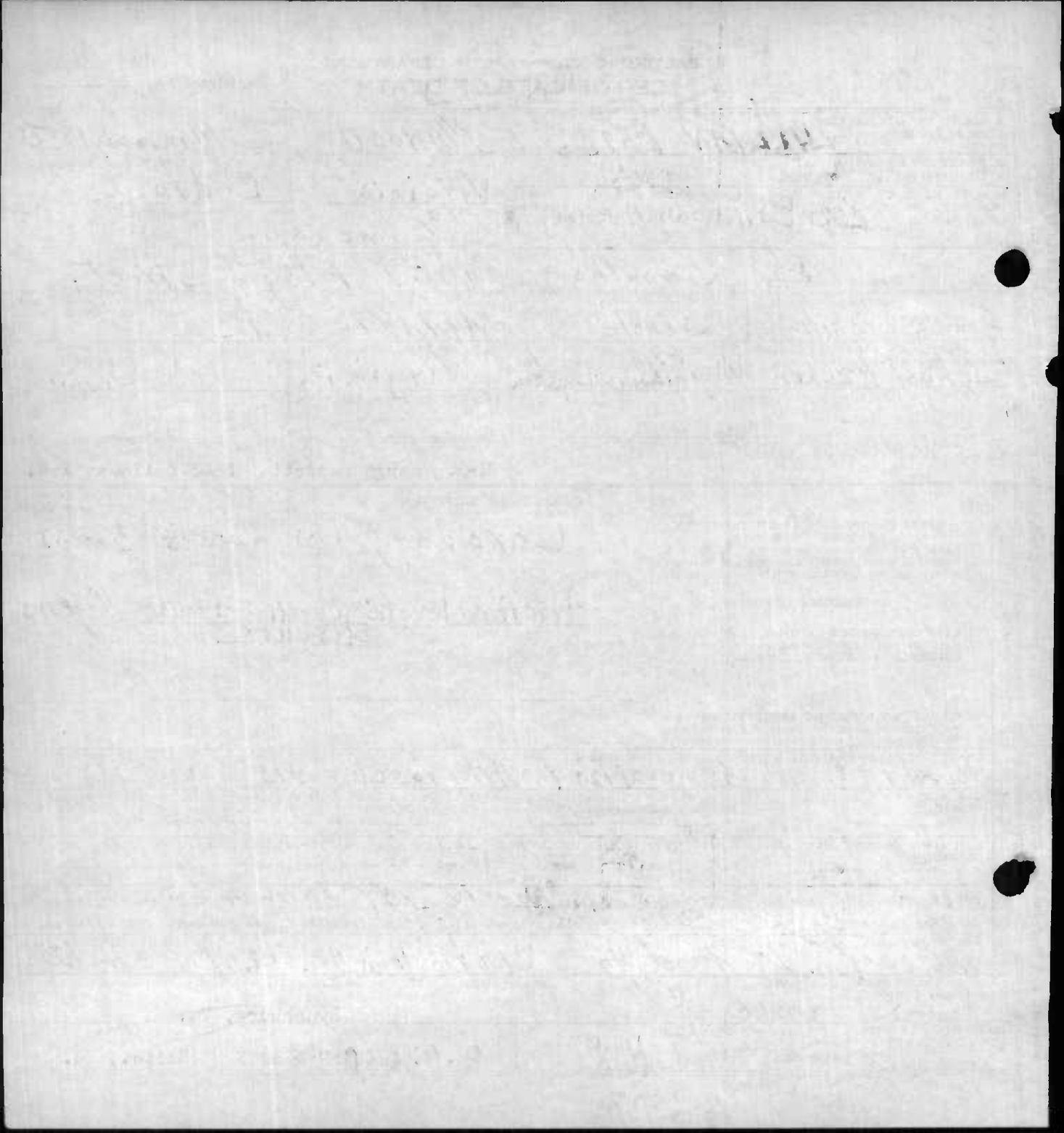
MAR 23 1950

V-150

V3491

937







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LOUISE M. STEVENSON

2. DATE  
OF  
DEATH

Mar. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

O. STREET ADDRESS (If rural, give location)  
1424 Dukeland St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1424 Dukeland St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 31, 1895

9. AGE (In year  
last birthday)

55 yrs.

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Christian Addicks

14. MOTHER'S MAIDEN NAME

Anna Hyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. B. L. Stevenson 1424 Dukeland St.

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

uraemia

12 hrs.

DUPLICATE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

chr. nephritis

3 yrs.

DUPLICATE

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

hemiplegia (left)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from Oct 1 - 1949, to March 22, 1950, that I last saw the deceased alive on 3/21, 1950, and that death occurred at 8:15 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. Medermast

M. O.

1136 Poplar Grove St

3/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/25/50

Loudon Park Cem.

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

W. 2 TACKER & SONS

Balto., Md.



CENTRAL BANK OF THE UNITED STATES

NEW YORK, N. Y.

1875 January 22

1875 January 22

1875 January 22

1875 January 22

1875 January 22

1875 January 22

1875 January 22

1875 January 22

1875 January 22

1875 January 22



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

360  
50 2668

OTTER

50 2668

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

William Otter

2. DATE  
OF  
DEATH

3-21-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

42 Sui Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto

D. STREET ADDRESS (If rural, give location)

1841 N Montford Ave

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 14<sup>th</sup> 1893

9. AGE (In years,

last birthday)

56

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Super Seller

10B. KIND OF BUSINESS OR INDUSTRY

J. Hoffman Co

13. FATHER'S NAME

Wm Otter

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

318-01-7953

17. INFORMANT

ADDRESS

Mrs Anna Otter 1841 N Montford Ave

18. 465X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cardiac Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Pulmonary Infarction

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-20, 1950, to 3-21, 1950, that I last saw the deceased alive on 3-21, 1950, and that death occurred at 11<sup>PM</sup>, from the causes and on the date stated above.

23A. SIGNATURE

Arnold Kramer

M. D.

23B. ADDRESS

Sui Hospital

23C. DATE SIGNED

3-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

Wilmington, Delaware

220 S. E. 170 St. Patterson Park Ave



STATEMENT OF THE DEPARTMENT OF HEALTH  
 OF THE DISTRICT OF COLUMBIA

DATE: \_\_\_\_\_

BY: \_\_\_\_\_

STATEMENT OF THE DEPARTMENT OF HEALTH  
 OF THE DISTRICT OF COLUMBIA

STATEMENT OF THE DEPARTMENT OF HEALTH  
 OF THE DISTRICT OF COLUMBIA

STATEMENT OF THE DEPARTMENT OF HEALTH  
 OF THE DISTRICT OF COLUMBIA

STATEMENT OF THE DEPARTMENT OF HEALTH  
 OF THE DISTRICT OF COLUMBIA

STATEMENT OF THE DEPARTMENT OF HEALTH  
 OF THE DISTRICT OF COLUMBIA



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and possibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2669

BIRTH NO. 50-02659

1. NAME OF DECEASED  
(Type or Print)

Timothy Jones

2. DATE  
OF  
DEATH

MAR 15 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1235 ELEXINGTON

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

2-9-50

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

14. MOTHER'S MAIDEN NAME

17. INFORMANT

ADDRESS

18. 7640 571.0  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
132 to 104 age 3  
ANTECEDENT CAUSES

CAUSE OF DEATH

Diarrhea

INTERVAL BETWEEN ONSET AND DEATH

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

James L. Gamble Jr. M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

Funerary Home 0002671

VS 150

Hospital Disposal

119a



New Tarkenton

changed code

764.0 to 571.0

5/1/51



correct age is especially important. Physicians: please write the causes of death clearly and legibly. The every item or information should be carefully supplied. The

MS--136328

50 2670

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2670

BIRTH NO.

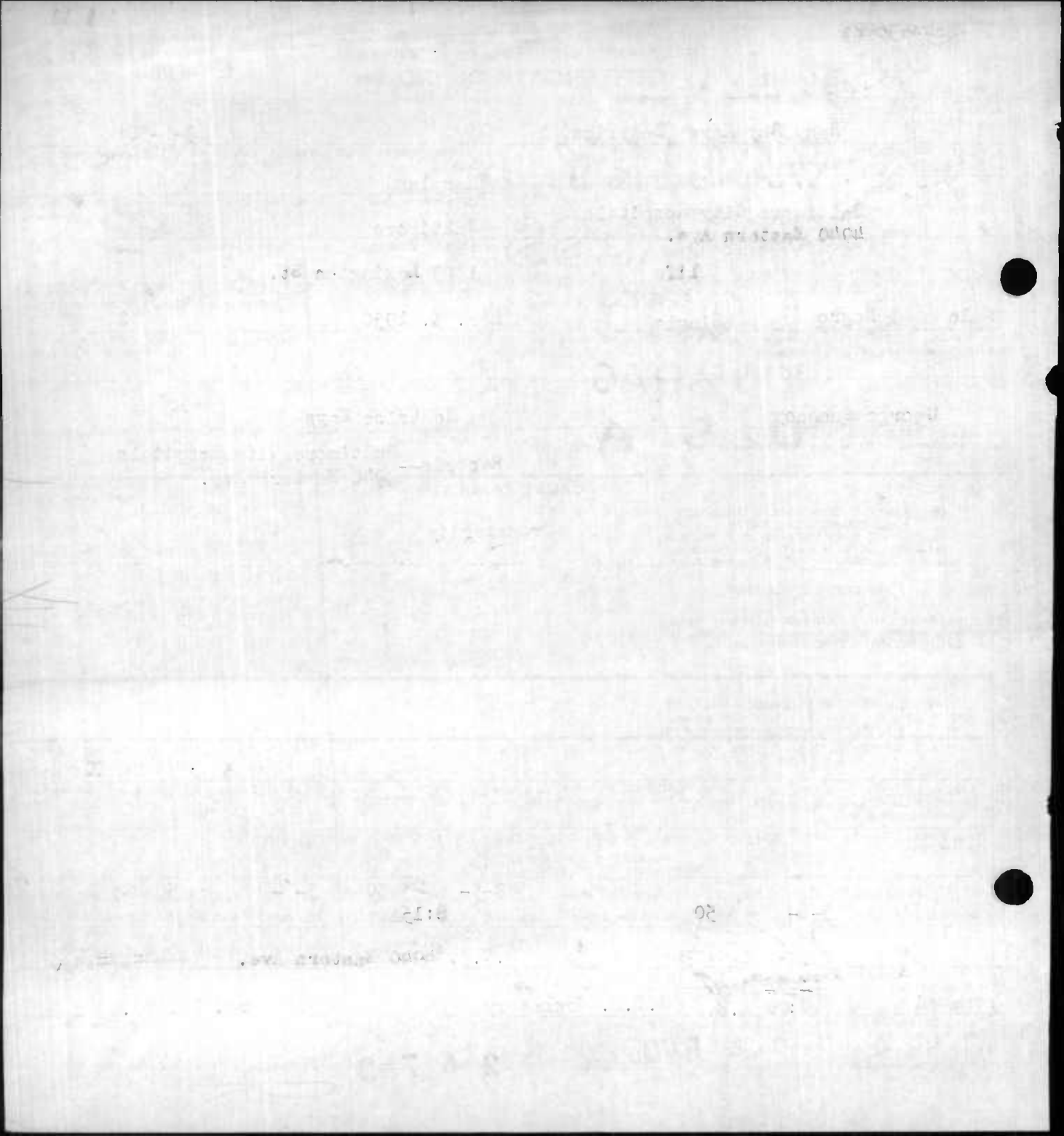
50-04678

1. NAME OF DECEASED (Type or Print) Baby Boy Keys (Beatrice)			2. DATE OF DEATH 3-6-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
6. Length of stay in Baltimore life			D. STREET ADDRESS (If rural, give location) 1203 Lexington St. E		
7. SEX Male	8. COLOR OR RACE Negro	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	10. DATE OF BIRTH Mar. 5, 1950	11. AGE (In years last birthday) 5-01 # Under 1 Year Months: 2 # Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME George Queeney			14. MOTHER'S MAIDEN NAME Beatrice Keys		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Baltimore City Hospitals Records--4940 Eastern Ave.	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Prematurity DUE TO (B) DUE TO (C)		
19A. DATE OF OPERATION 2			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-5-1950, to 3-6-1950, that I last saw the deceased alive on 3-6-1950 and that death occurred at 8:15 A.M., from the causes and on the date stated above.					
23A. SIGNATURE J. J. Hogan			23B. ADDRESS B.C.H. 4940 Eastern Ave.		23C. DATE SIGNED 3-17-1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated		24B. DATE 3-17-1950 9:00 A.M.		24C. NAME OF CEMETERY OR CREMATORY B.C.H. Crematory	
24D. LOCATION (City, town, or county) Baltimore, 24, Md.		25. FUNERAL DIRECTOR ADDRESS			
DATE RECEIVED BY LOCAL REGISTRAR MAR 23 1950		REGISTRAR'S SIGNATURE Huntington Hillman		25. FUNERAL DIRECTOR ADDRESS 2672	

VS 150

159











CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

Decd. \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Married \_\_\_\_\_

Profession \_\_\_\_\_

Place of Birth \_\_\_\_\_

Usual Residence \_\_\_\_\_

Place of Death \_\_\_\_\_

Date of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Cause of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

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Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and fully.

M# 250

50 2672

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2672

Registered No.

BIRTH NO. 50-05403

1. NAME OF DECEASED (Type or Print) William Edward Mc Cain			2. DATE OF DEATH March 14, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-05		
D. STREET ADDRESS (If rural, give location) 1645 E. Fayette Street			E. LENGTH OF STAY IN BALTIMORE One Hour & 20min.		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 14, 1950	9. AGE (In years last birthday) 1	10. Under 1 Year Months: Days: Hours: Min. 1 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10B. KIND OF BUSINESS OR INDUSTRY -		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME James Edward Mc Cain			14. MOTHER'S MAIDEN NAME Myra Blackston		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT Hospital Records			ADDRESS		

MEDICAL CERTIFICATION	18. 76210 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Anoxemia DUE TO (B) Aggravation of mechanism DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 min	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
	II	

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 14, 1950, to March 14, 1950 that I last saw the deceased alive on March 14, 1950, and that death occurred at 4:10 A., from the causes and on the date stated above.					
23A. SIGNATURE William L. Hartmann M. D.		23B. ADDRESS 601 N. Broadway		23C. DATE SIGNED March 16, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Hof Desford	
24D. LOCATION (City, town, or county)		24E. DATE RECEIVED BY LOCAL REGISTRAR MAR 23 1950		24F. REGISTRAR'S SIGNATURE Huntington	
24G. FUNERAL DIRECTOR 2674		24H. ADDRESS		24I. DATE RECEIVED BY LOCAL REGISTRAR MAR 23 1950	



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2673

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Maude J. Macklin

2. DATE  
OF  
DEATH

Mar. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1901 McCulloh St.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Oct. 17, 1889

9. AGE (In years;  
last birthday)

60 yrs.

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

South Hill, Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Louis Jones Sr.

14. MOTHER'S MAIDEN NAME

Amanda Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lovinia Dougherty 1901 McCulloh St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

Myocardial Regeneration

4 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Generalized Arteriosclerosis

6 wks.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 2/20, 1950, to 3/20, 1950, that I last saw the  
deceased alive on 3/20, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1543 Penna. Ave

3/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/23/50

Arbutus Cemetary

Balto. Co. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

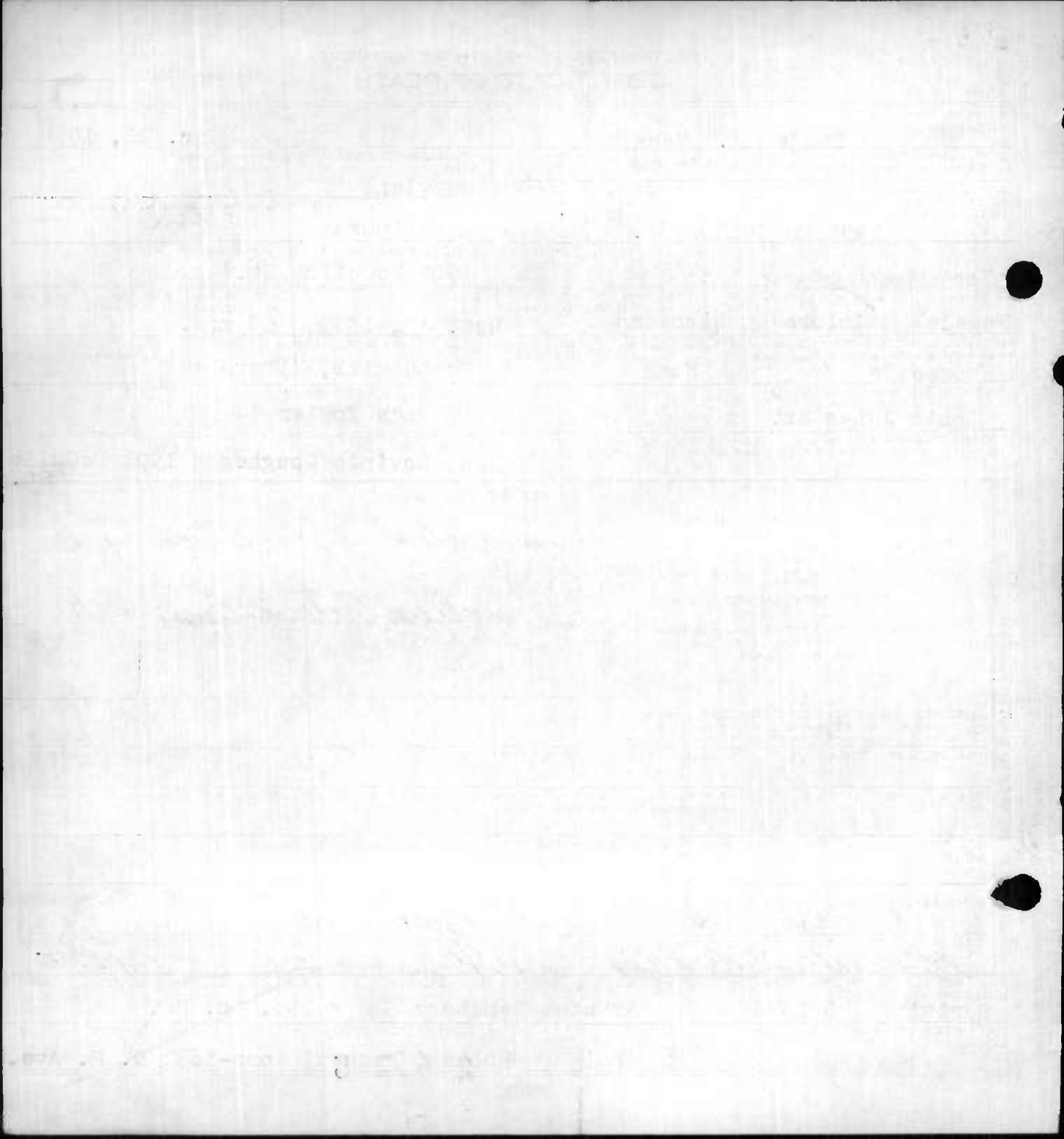
Wm. H. H. H. H. H.

Holman Funeral Home-1631 D. H. Ave.

VS 150

931







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2674  
Registered No.

630  
BIRTH NO. 2674

1. NAME OF DECEASED (Type or Print) JAMES HURD		2. DATE OF DEATH March 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-01	
c. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 208 W. Pleasant Street	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3-4-1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Contractors	9. AGE (In years last birthday) 45
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes W.W. #1		16. SOCIAL SECURITY NO. none	
17. INFORMANT Pearl Crosby - 207 E. 2nd St.		ADDRESS	
18. 434.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure		CAUSE OF DEATH (A) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE Earl L. Royer		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL INVESTIGATOR.....	
23C. DATE SIGNED March 20, 1950		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE 3/23/50		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 23 1950		REGISTRAR'S SIGNATURE Huntley J. Halliday	
25. FUNERAL DIRECTOR A. E. Tabbe - 918 - ✓		ADDRESS 208 W. Pleasant Street	







correct age is especially important. Physicians are especially important. Every item of information should be carefully supplied. The causes of death clearly and briefly.

300

50 2675

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2675

Registered No.

1. NAME OF DECEASED (Type or Print) <b>Marilyn L. Tuite</b>		2. DATE OF DEATH <b>3-21-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		C. CITY OR TOWN (If outside corporate limits, name of city and give township) <b>Baltimore</b> <b>28-04</b>	
E. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>4502 Old Frederick Rd</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Dec. 8, 1949</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years, last birthday) <b>3</b> <b>13</b> <b>13</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis Tuite</b>		14. MOTHER'S MAIDEN NAME <b>June Burrows</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louis Tuite, 4502 Old Frederick Rd.</b>		ADDRESS	
18. <b>788.8</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hyperpyrexia</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Unknown cause</b>			
19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Mar. 21, 1950</b> to <b>Mar. 21, 1950</b> that I last saw the deceased alive on <b>Mar. 21, 1950</b> , and that death occurred at <b>12:00 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Albert J. Weiss</b> M. D.		23B. ADDRESS <b>Sinai Hospital</b>	
23C. DATE SIGNED <b>3-21-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/24/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd. Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 23 1950</b>		REGISTRAR'S SIGNATURE <b>Arthur J. Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>4101 Edmondson Ave.</b>		ADDRESS	



CERTIFICATE OF DEATH

State of Illinois

County of Cook

City of Chicago

Dec. 1, 1911

Age

Sex

Color

Married

Single

Deceased

Survivor



3# 500  
50 2676

50 2676

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Hattie Z. Baum

2. DATE  
OF  
DEATH

3/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1112 S. Carey St.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1112 S. Carey St.

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 2, 1868

9. AGE (In years  
last birthday)

82

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Harrison Fink

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Grace Smith, 1112 S. Carey St.

18. 446X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Uremia - nephrosclerosis

4 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Generalized arteriosclerosis

?

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1945 to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 4:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Mona B. Knepper

M. D.

548 Fulton Ave

3-23-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

3801 Frederick Rd. Balto.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Md.

MAR 23 1950

Huntington Williams, M.D.

Harry F. Smith, 4101 Edmondson A



CERTIFICATE OF DEATH

1/1/1900

1/1/1900

1/1/1900

1/1/1900

1/1/1900

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1/1/1900

1/1/1900



correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Every item of information should be carefully supplied.

50 2677

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK J. JOYCE

2. DATE  
OF  
DEATH

March 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE MD

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

1413 Mount Royal Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE, MARYLAND

D. STREET ADDRESS (If rural, give location)

14-01

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SINGLE

B. DATE OF BIRTH

?

9. AGE (In years  
last birthday)

50

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR  
INDUSTRY

HOME EQUIPMENT

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

(R) HOUSEHOLD APPLIANCES

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHN RALTON 3009 Maryland Ave

18. OR XX

CAUSE OF DEATH

BALTO. MD.

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ANEURYSM - Abdominal Aorta, RUPTURED 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 6, 1950, to March 6, 1950, that I last saw the deceased alive on MARCH 6, 1950, and that death occurred at 9:10 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Anthony C. Verone

23B. ADDRESS

Maryland Gen. Hosp

23C. DATE SIGNED

3/8/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR

5118 Guyton Oak Ave.

2518 2nd St. Annapolis

MAR 23 1950

VS 150

V9468

300







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Juliet D. Fonteneau

2. DATE  
OF  
DEATH

Mar. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Pine Crest Sanitariums

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2505 Maryland Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House-wife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

William D. McCord

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Francis W. Buschman 2505 Md. Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Chronic Myocardial Degeneration with Myocarditis, arteriosclerosis and hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Generalized arteriosclerosis

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Dec. 29, 1948, to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 10:20 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Malvin N. Border

23B. ADDRESS

M. D.

2030 W. Fayette St

23C. DATE SIGNED

3/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-24-1950

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore,

Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 23 1950

REGISTRAR'S SIGNATURE

Thurston W. Davis, M.D.

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.



Dr. Gordon  
2030 W Fayette St  
7-9 PM



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50 2679

50 2679

1. NAME OF DECEASED (Type or Print) <i>Hugh Hutchinson alias Hutson</i>			2. DATE OF DEATH <i>March 21, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1009 N. Wolfe St.</i>			C. CITY OR TOWN (If outside corporate limits, write full name, and give township) <i>Baltimore 7-04</i>		
Length of stay in Baltimore <i>18 mos.</i>			D. STREET ADDRESS (If rural, give location) <i>1009 N. Wolfe St.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 15, 1894</i>	9. AGE (In years last birthday) <i>56</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>White Plains, Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Lula Walker</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Nonie Bell Bents</i>		
			ADDRESS <i>Bents 1009 N. Wolfe St.</i>		

18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO <i>Hypertensive Cardiovascular Disease</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 3, 1950</i> to <i>March 4, 1950</i> that I last saw the deceased alive on <i>March 3, 1950</i> and that death occurred at <i>1:30 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>J. K. Adams</i>		23B. ADDRESS <i>1242 N. Caroline</i>		23C. DATE SIGNED <i>3-23-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-24-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Anne Arundel Co., Md.</i>		25. FUNERAL DIRECTOR <i>Randolph Wallick</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		REGISTRAR'S SIGNATURE <i>W. H. Williams</i>		ADDRESS <i>1532 Biddle St.</i>	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

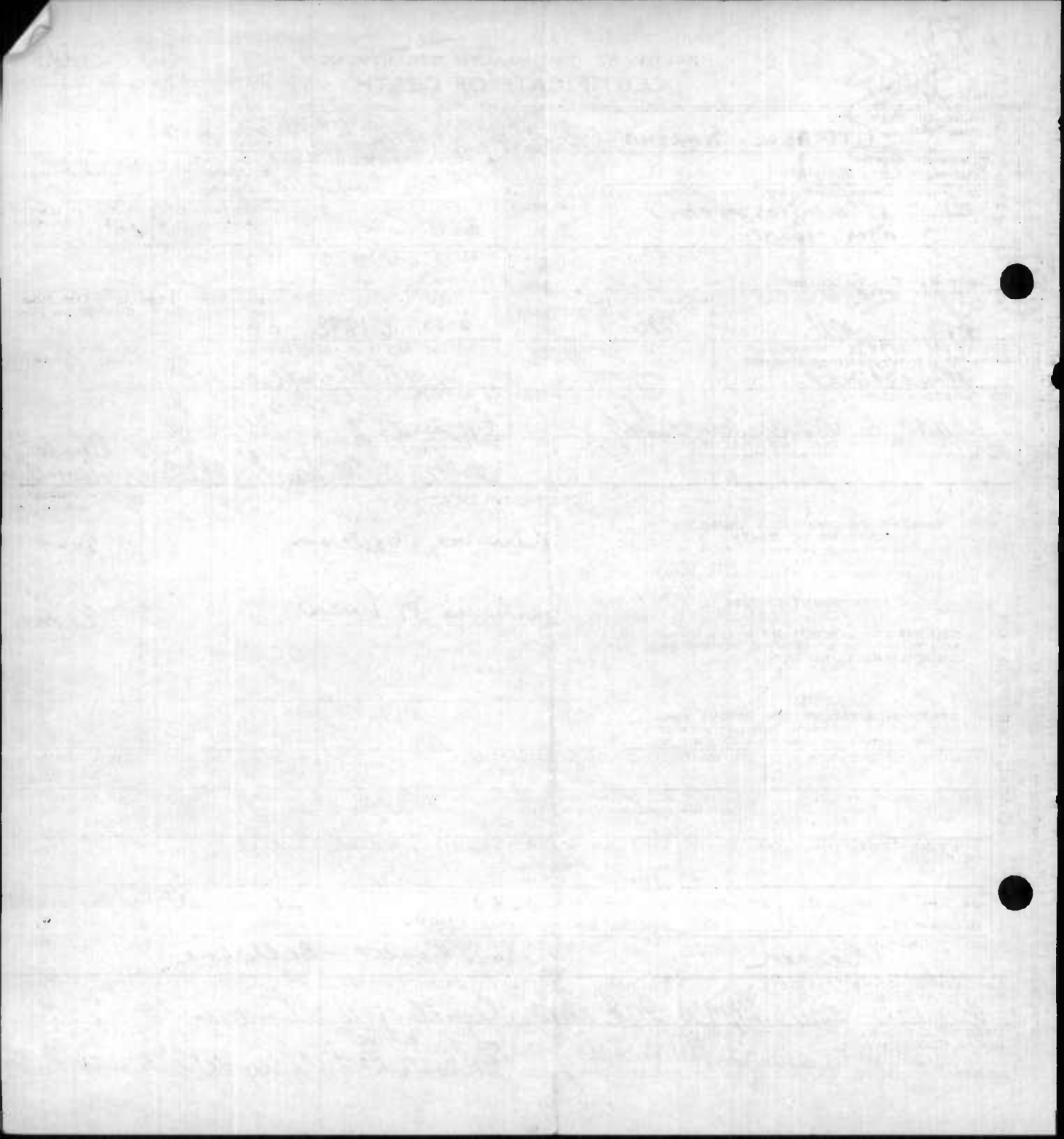
50 2680  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MITCHELL, MARTHA Martha Lethel Mitchell</b>		DATE OF DEATH <b>3.21.50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL BALTIMORE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Dundalk</b>	
D. STREET ADDRESS (If rural, give location)			
Length of stay in Baltimore Yrs. Mos. Days			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>3.15.25/1893</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired)		9. AGE (In years last birthday) <b>56</b>	
<b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Isaac S. Blankenship</b>		14. MOTHER'S MAIDEN NAME <b>Emma J. Shively</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<b>Yes, no or unknown</b>		<b>Walter R. Mitchell, 2112 Dundalk Ave.</b>	

MEDICAL CERTIFICATION	18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Gedaema</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>2 yrs</b>
	ANTECEDENT CAUSES <b>Anchosis of Liver</b> DUE TO		
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>3.21.50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3.9.50</b> , 19 <b>50</b> , to <b>3.21.50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3.21.50</b> , 19 <b>50</b> , and that death occurred at <b>7.50 p. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>O Becker</b>		23B. ADDRESS <b>Sinai Hospital - Baltimore</b>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>March 24, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery, Baltimore Co., Md.</b>	
24D. LOCATION (City, town, or county)		24E. LOCAL REGISTRAR <b>Mar 23 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md.</b>	
24G. FUNERAL DIRECTOR <b>Poland R. Fisher, 2112 Dundalk Ave.</b>		24H. ADDRESS			







PLEASE PRINT FULL NAME, WITH EXPANDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50 2681

1. NAME OF DECEASED  
(Type or Print)

CHARLES W. MILLER

2. DATE  
OF  
DEATH

3/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Maryland General

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside, incorporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2102 Dobler Ave #18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Real Estate

13. FATHER'S NAME

William A. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. M. Ursula Miller - 2102 Dobler Ave.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 3/12, 1950, to 3/22, 1950, that I last saw the deceased alive on 3/22, 1950, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/25/50

Loudon Park Cem.

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 23 1950

27681

2 WM J & S TROKNER & SONS

Balto., Md.



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

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correct age is especially important. Physicians write the causes of death carefully and legibly. The cause of death should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clark, Mr Lawrence L.

2. DATE  
OF  
DEATH

Mar. 22-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Home For Incurables, 700 W. 40th St

Length of stay in Baltimore

7 years

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Aircraft Tech.

10B. KIND OF BUSINESS OR INDUSTRY

Aircraft Service

13. FATHER'S NAME

Noble Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL SECURITY NO.

178-09-9003

8. DATE OF BIRTH

Apr. 21-1906

9. AGE (in years last birthday)

43

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min

11. BIRTHPLACE (State or foreign country)

Warren, Penn

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

Huna E. Langworthy

17. INFORMANT

ADDRESS

Laura E. Fischer - 700 W. 40th St

1B. 345. X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Multiple Sclerosis

ONE TO

INTERVAL BETWEEN ONSET AND DEATH

3 yrs. 3 mo

ANTECEDENT CAUSES

(B)

ONE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 24<sup>th</sup> 1948 to March 22<sup>nd</sup> 1950, that I last saw the deceased alive on March 22<sup>nd</sup> 1950, and that death occurred at 6<sup>55</sup> P. M., from the causes and on the date stated above.

23A. SIGNATURE

Thomas Conrad Wolff

M. O.

23B. ADDRESS

11 E. Chase St. Baltimore 2 Md

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

3/24/50

24C. NAME OF CEMETERY OR CREMATORY

Warren Cem.

24D. LOCATION (City, town, or county)

Warren, Pa.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 23 1950

REGISTRAR'S SIGNATURE

Thomas Conrad Wolff

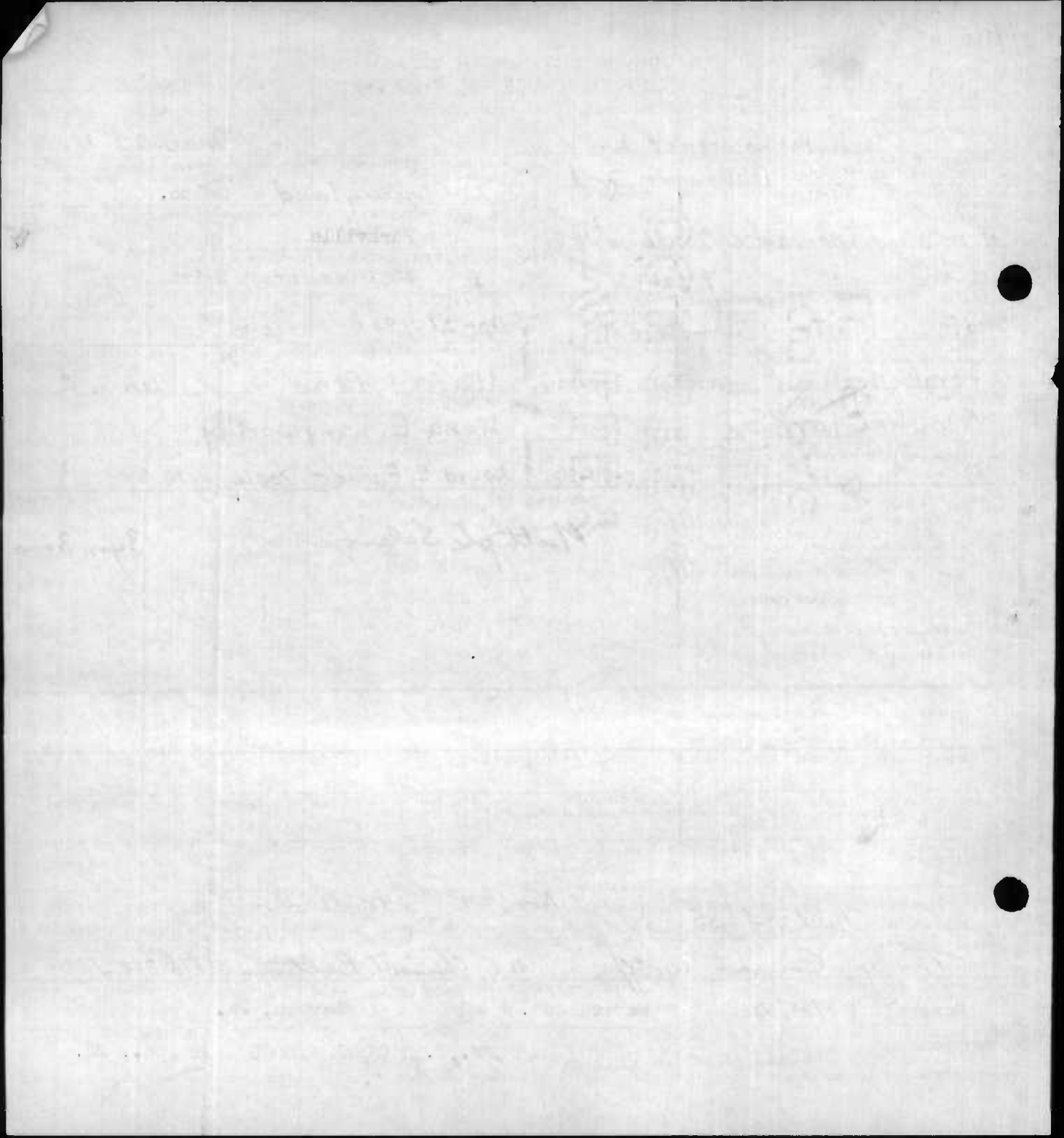
25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.







# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Margaret V. McCubbin

(MARGARET V. O'CONNOR )

2. DATE  
OF  
DEATH

March 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

3026 Mathews Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1714 N. Washington Street

E. Length of stay in Baltimore

Life

F. SEX

Female

G. COLOR OR RACE

White

H. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Divorced

I. DATE OF BIRTH

Jan. 4th., 1913

J. AGE (In years last birthday)

37 38 (37)

K. Under 1 Year Months: Days

2 16

L. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Patrick Burke

14. MOTHER'S MAIDEN NAME

Ruth Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

None

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Runge-- 3026 Mathews Street

18. 433.2

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Functional heart disease

DOE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

195F asher

23B. CHIEF MEDICAL EXAMINER..... ☒ ASSISTANT MEDICAL EXAMINER..... ☐ M.D. MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED March 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-25-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State)

Edmondson Avenue, Balto: Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

50000

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc.-1735 Harford Avenue



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of military		26. Signature of religious		27. Signature of social		28. Signature of cultural	
29. Signature of sports		30. Signature of entertainment		31. Signature of education		32. Signature of science	
33. Signature of technology		34. Signature of industry		35. Signature of commerce		36. Signature of finance	
37. Signature of law		38. Signature of medicine		39. Signature of health		40. Signature of environment	
41. Signature of energy		42. Signature of transportation		43. Signature of communication		44. Signature of information	
45. Signature of media		46. Signature of arts		47. Signature of culture		48. Signature of heritage	
49. Signature of history		50. Signature of geography		51. Signature of politics		52. Signature of government	
53. Signature of military		54. Signature of religious		55. Signature of social		56. Signature of cultural	
57. Signature of sports		58. Signature of entertainment		59. Signature of education		60. Signature of science	
61. Signature of technology		62. Signature of industry		63. Signature of commerce		64. Signature of finance	
65. Signature of law		66. Signature of medicine		67. Signature of health		68. Signature of environment	
69. Signature of energy		70. Signature of transportation		71. Signature of communication		72. Signature of information	
73. Signature of media		74. Signature of arts		75. Signature of culture		76. Signature of heritage	
77. Signature of history		78. Signature of geography		79. Signature of politics		80. Signature of government	



425  
50 2684

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2684  
Registered No.

BIRTH NO. *K.R.*

1. NAME OF DECEASED  
(Type or Print)

*Baby Boy Wilkinson*

2. DATE OF DEATH

*March 21/1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*14214 Queen n*

B. FULL NAME OF HOSPITAL OR INSTITUTION

*JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*Box 169- 5th. Avenue*

Length of stay in Baltimore

*Life*

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*none*

10B. KIND OF BUSINESS OR INDUSTRY

*none*

13. FATHER'S NAME

*Robert WILKINSON*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
*none*

8. DATE OF BIRTH

*3-20-50*

9. AGE (In years, last birthday)

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

*MD*

12. CITIZEN OF WHAT COUNTRY?

*USA*

14. MOTHER'S MAIDEN NAME

*Clara Jane Fowler*

17. INFORMANT

ADDRESS

*JOHNS HOPKINS HOSPITAL*

18. *762.5*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

*Neonatal anoxia*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Atelectasis*

DUE TO

(C)

*Pneumonia*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *3/20*, 19*50*, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at *10:20* m., from the causes and on the date stated above.

23A. SIGNATURE

*C.C. Robinson*

M.D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

*burial*

24B. DATE

*3/23/50*

24C. NAME OF CEMETERY OR CREMATORY

*WOODLAWN CEMETERY*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*W. H. Williams*

25. FUNERAL DIRECTOR

ADDRESS

*HENRY SANDER & SONS, INC*

VS 150 1950

BALTIMORE - 13, MD.

159



STATE OF NEW YORK  
CERTIFICATE OF DEATH

188

John J. ...  
...  
...

...  
...



350  
50 2685BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2685  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Antonio Bottone (ANTONIO BOTTONE)

2. DATE  
OF  
DEATH

3/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

2315 Harford Road

Length of stay in Baltimore

55 yrs.

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

11/1 - 1872

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unemployed - cabinet maker

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Europe - ITALY

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Dominic Bottone

14. MOTHER'S MAIDEN NAME

Antonian Bucherio

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT 2315 Harford Road  
Angelo Bottone

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Arteriosclerotic Heart  
Disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Generalized Arterio-  
sclerosis

## II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21, 1950, to 3/21, 1950, that I last saw the  
deceased alive on 3/21, 1950, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

3/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

HENRY SANDER &amp; SONS, INC.

VS 150-31950

BALTIMORE - 13, MD.

93D







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2686  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

WILLIAM STUMPF, SR.

2. DATE  
OF  
DEATH

March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1700 N. Regester Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1700 N. Regester Street

C. Length of stay in Baltimore

33 yrs

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 2, 1886

9. AGE (in years last birthday)

63

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Store keeper

10B. KIND OF BUSINESS OR INDUSTRY

Own business

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Stumpf

14. MOTHER'S MAIDEN NAME

Matilda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT 1700 N. Regester Street  
Mrs Margaret Stumpf

18. 480X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Lobar Pneumonia

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Influenza

DUE TO

10 days

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 11, 1950 to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 6:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Albert Eisenberg

M. D.

23B. ADDRESS

2025 E North Ave

23C. DATE SIGNED

March 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

3/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Henry Sanders & Sons, Inc.

25. FUNERAL DIRECTOR

HENRY SANDERS & SONS, INC.

ADDRESS

MAR 23 1950

VS 150

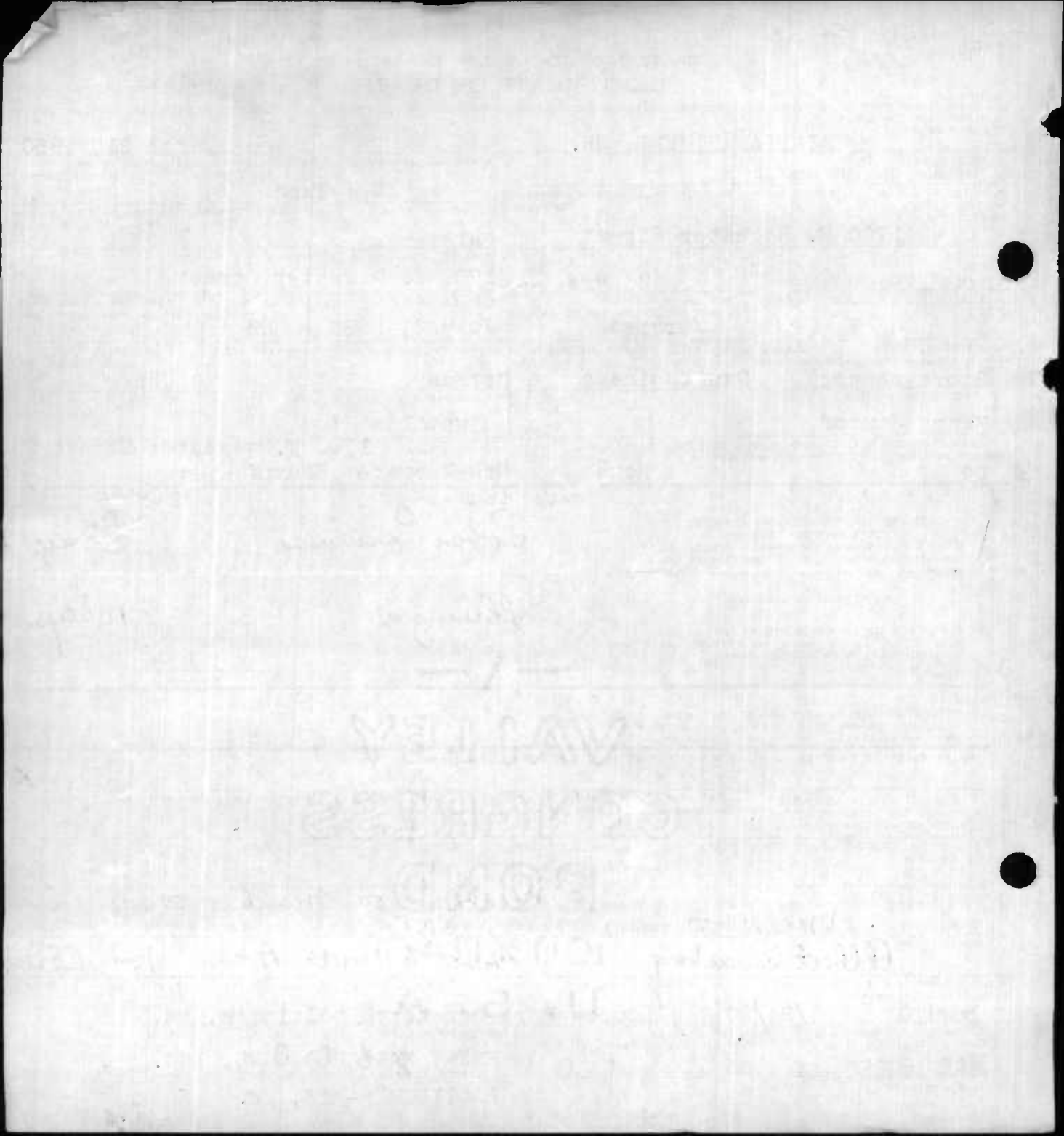
BALTIMORE - 13, MD.

33a

MEDICAL CERTIFICATION

PLEASE WRITE CLEARLY, WITH CAPS AND INK. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. THE correct age is especially important. Physicians: please write the causes of death clearly and legibly.















correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item or information should be carefully supplied. The

50 2688

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2688

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>HILDA E. POPE</i>		2. DATE OF DEATH <i>3/21/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 13-67</i>			
Length of stay in Baltimore <i>18 years</i>		D. STREET ADDRESS (If rural, give location) <i>4015 Roland Ave #11</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Aug 7 1932</i>	9. AGE (In years last birthday) <i>17</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W. Sales Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>R.H.D. Willis</i>		14. MOTHER'S MARDEN NAME <i>Rose C. Monohue</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-09-7594</i>		INFORMANT ADDRESS <i>Clarence C. Pope 4015 Roland Ave.</i>	
18. <i>331 X</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cerebrovascular accident</i>			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Hypertension</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/20</i> 19 <i>50</i> , that I last saw the deceased alive on <i>3/20</i> , 19 <i>50</i> , and that death occurred at <i>9:20</i> Am., from the causes and on the date stated above.					
23A. SIGNATURE <i>Charles J. Black</i> M.D.		23B. ADDRESS <i>Maryland General</i>		23C. DATE SIGNED <i>3/21/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>March 24-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		24E. FUNERAL DIRECTOR <i>Burges Funeral Home</i>		24F. ADDRESS <i>3631 Falls Road</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>3/20/50</i>		REGISTRAR'S SIGNATURE <i>William H. ...</i>		25. FUNERAL DIRECTOR ADDRESS	



NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS

10

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS

DECEASED WAS



50 2689

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2689

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Minnie E. Fardwell

2. DATE  
OF  
DEATH

March 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

St. Paul Convalescent Home  
2305 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1937 W. North Avenue

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

August 3, 1863

9. AGE (In years last birthday)

86

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
U S A

13. FATHER'S NAME

John MacGlaughlin

14. MOTHER'S MAIDEN NAME

Mary Mayfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miss Marion W. Fardwell 3610 Elm Avenue

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Arteriosclerosis Heart

DUE TO

Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

General Debilitation 1 yr

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Mar 10, 1950, to Mar 22, 1950, that I last saw the deceased alive on Mar 22, 1950, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert B. Tunney

M. D.

23B. ADDRESS

920 St Paul St

23C. DATE SIGNED

3-22-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Robert B. Tunney

25. FUNERAL DIRECTOR

ADDRESS

Burges Funeral Home 3631 Falls Road



CERTIFICATE OF DEATH

March 22, 1960

Mr. James E. [Name]

Age 65

St. Louis, Missouri

Residence

1932 E. [Address]

March 22, 1960

St. Louis, Missouri

U.S.A.

Married

Married

John [Name]

John [Name] [Address]

No.

St. Louis, Missouri

March 22, 1960

St. Louis, Missouri

March 22, 1960



415  
50 2690

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2690

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Wilhelmina Frances Filippino</i>			2. DATE OF DEATH <i>MARCH 22, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>1816 W. Pratt St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 19-04</i>		
Length of stay in Baltimore <i>71 YRS.</i>			D. STREET ADDRESS (If rural, give location) <i>1816 W. Pratt St.</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>MARCH 28, 1878</i>	9. AGE (In years last birthday) <i>71</i>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>GEORGE FISCHER</i>			14. MOTHER'S MAIDEN NAME <i>FRANCES REAHL</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO NONE</i>			16. SOCIAL SECURITY NO. <i>NONE</i>		
17. INFORMANT <i>OTTO. Filippino</i>			ADDRESS <i>1816 W. PRATT ST.</i>		

MEDICAL CERTIFICATION

18. <i>446 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Uremia - Nephrosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Generalized arteriosclerosis</i>		<i>?</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Viral Bronchitis</i>		<i>5 wks</i>

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 14*, 1950, to *MARCH 22, 1950*, that I last saw the deceased alive on *3-22*, 1950, and that death occurred at *5:00 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Marie B. Schreiber</i>	23B. ADDRESS <i>54 S. Fulton Ave</i>	23C. DATE SIGNED <i>3.22.50</i>
---	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>MARCH 25, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>NEW CATHEDRAL</i>	24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i>
--	------------------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>	REGISTRAR'S SIGNATURE <i>Marie B. Schreiber</i>	25. FUNERAL DIRECTOR <i>20. H. Schwab</i>	ADDRESS <i>2101 Frederick Ave.</i>
--	--	--	---------------------------------------







520  
50 2691

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2691  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter E THOMAS

2. DATE  
OF  
DEATH

March 22, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE b. COUNTY

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

d. STREET ADDRESS (If rural, give location)

1122 Carroll St.

c. Length of stay in Baltimore

67 yrs - Mos. Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 5 - 1882

9. AGE (In years last birthday)

67

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10b. KIND OF BUSINESS OR INDUSTRY

Wholesale Grocery

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Julius Thomas

14. MOTHER'S MAIDEN NAME

Johanna - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-01-9668

17. INFORMANT

ADDRESS

Mrs. Elizabeth Thomas 1122 Carroll St

18. 451 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm of descending aorta

DUE TO arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ AT WORK

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

Earl H. Royer

23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒

23c. DATE SIGNED

March 23, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

March 25 - 50

24c. NAME OF CEMETERY OR CREMATORY

Meadowridge Cem

24d. LOCATION (City, town, or county)

Dorsey Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 23 1950

REGISTRAR'S SIGNATURE

Earl H. Royer

25. FUNERAL DIRECTOR

Geoff. Berger Jr 1512 Hollins St

ADDRESS

MARGIN RESERVED FOR BINDING  
PLEASE WRITE MAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



CERTIFICATE OF DEATH

10-1-1918

10-1-1918

10-1-1918

10-1-1918



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

2692  
366

50 2692

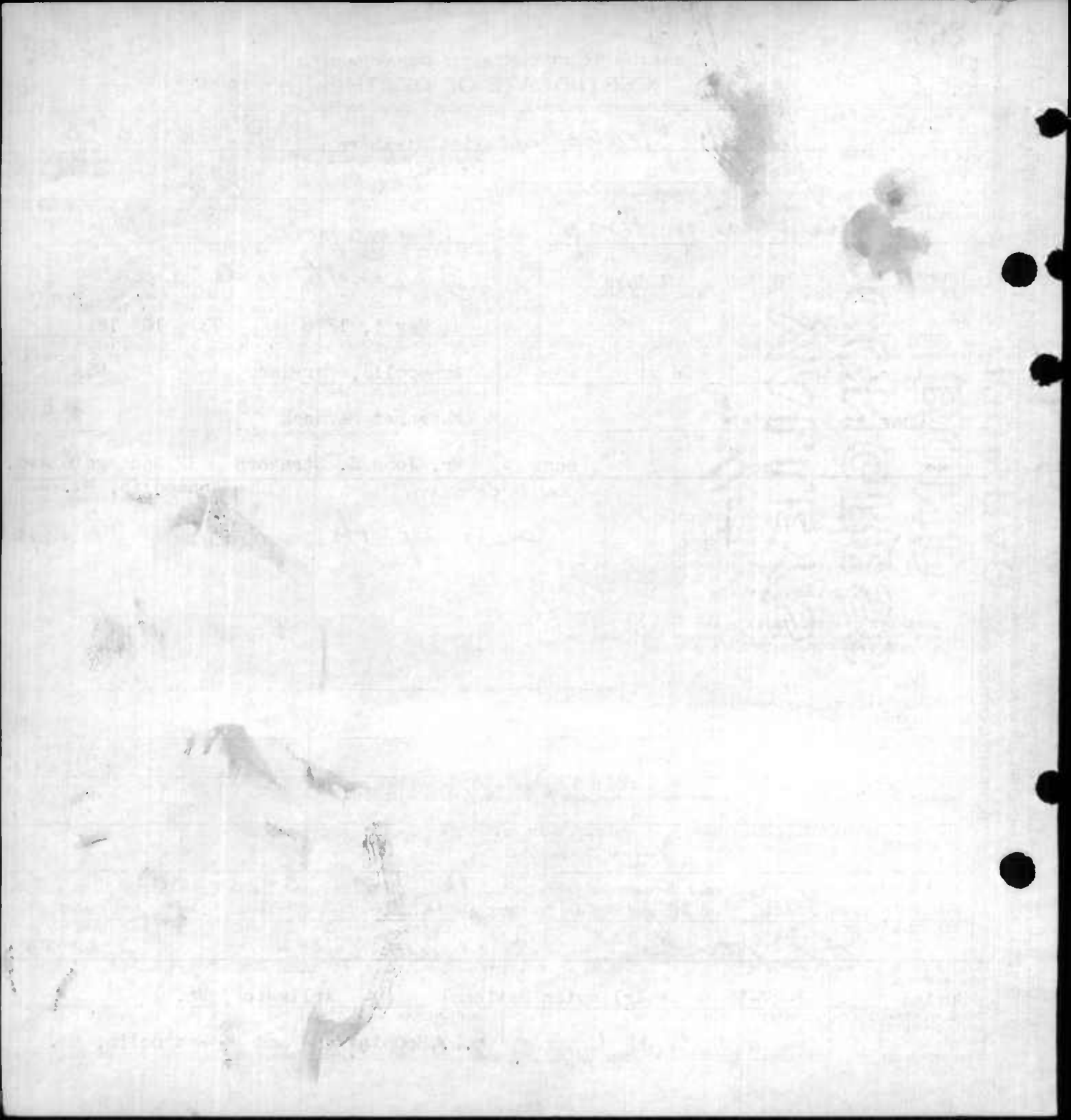
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Juliet Strahorn</i>		2. DATE OF DEATH <i>3-23-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>P.A.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Annapolis 5210</i>	
c. Length of stay in Baltimore <i>7 days</i>		D. STREET ADDRESS (If rural, give location) <i>32 Smith Gate Circle</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>May 5, 1876</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stenographer</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Maryland</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>Court</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles H. Dexter</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Merdock</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mr. John S. Strahorn</i>	
18. <i>4201</i>		ADDRESS <i>32 Southgate Ave.</i>	

18. <i>4201</i>		CAUSE OF DEATH <i>Coronary thrombosis</i>		19. PERIOD BETWEEN ONSET AND DEATH <i>7 days</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary thrombosis</i>		DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>3-16</i> , 19 <i>50</i> , to <i>3-23</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-23</i> , 19 <i>50</i> , and that death occurred at <i>12:50 P.M.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>J. H. H. H.</i>		23B. ADDRESS <i>Univ. Hosp.</i>		23C. DATE SIGNED <i>3-23-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-27-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>
24D. LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>		25. FUNERAL DIRECTOR <i>B.L. Hooping and Son</i>		
24E. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		24F. REGISTRAR'S SIGNATURE <i>...</i>		24G. ADDRESS <i>Annapolis, Md.</i>







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

353

50 2693

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2693

1. NAME OF DECEASED (Type or Print) <b>THEODORE HUDNET</b>			2. DATE OF DEATH <b>3/21/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>I455 Henry Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 24-02</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>I455 Henry Street</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>9/22/1875</b>	9. AGE (In years last birthday) <b>74</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. - Factory</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Assau Packing Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Theodore I. Hudnet</b>			14. MOTHER'S MAIDEN NAME <b>Mary Dolby</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, do or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Family - Same</b>		

MEDICAL CERTIFICATION	18. <b>151 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Malignancy of Stomach with Metastasis to Liver</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
	ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) _____		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Feb 21, 1950</b> , to <b>March 21, 1950</b> that I last saw the deceased alive on <b>March 20, 1950</b> , and that death occurred at <b>12:30 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. S. H. Baranov</b>		23B. ADDRESS <b>436 E Fort Ave.</b>		23C. DATE SIGNED <b>3/22/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>3/25/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 23 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. H. Williams</b>	25. FUNERAL DIRECTOR <b>Wm. H. Williams</b>	ADDRESS <b>- I30 E. Fort Ave.</b>
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156 X1

46 B







D-520

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2694

Registered No.

50 2694

1. NAME OF DECEASED (Type or Print) <b>LEVIN J. DUNNOCK</b>			2. DATE OF DEATH <b>3/22/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland 3808 Second Street			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>00</b>			C. CITY OR TOWN (If outside corporate limits, give RURAL, and give township) <b>Baltimore 25-04</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3808 Second Street</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>4/15/1880</b>	9. AGE (In years, last birthday) <b>69</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self Const.</b>	11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John A. Dunnock</b>			14. MOTHER'S MAIDEN NAME <b>Mary A. Jones</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Family - Same</b> ✓		

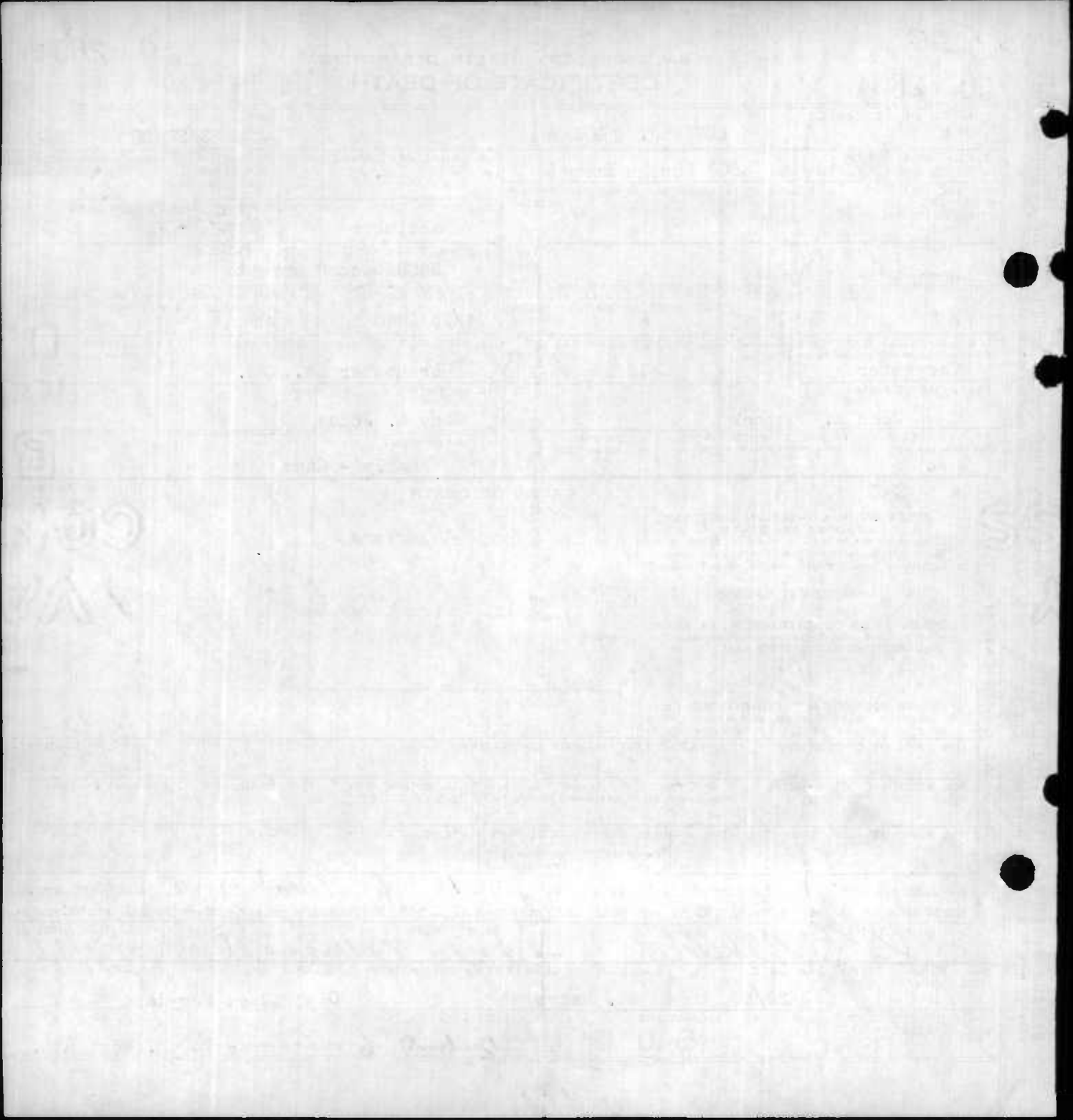
MEDICAL CERTIFICATION

18. <b>481 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Influenza</b> DUE TO	CAUSE OF DEATH <b>Influenza</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pericarditis</b> DUE TO	<b>Pericarditis</b>	<b>1 year</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Jan 16, 1950</b> , to <b>March 22, 1950</b> , that I last saw the deceased alive on <b>March 22, 1950</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>W. S. Webb</b>	23B. ADDRESS <b>1279 William St.</b>	23C. DATE SIGNED <b>3/23/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	24B. DATE <b>3/25/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>
24D. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 23 1950</b>	REGISTRAR'S SIGNATURE <b>W. S. Webb</b>	25. FUNERAL DIRECTOR <b>W. S. Webb</b>	ADDRESS <b>130 E. Fort Ave.</b>
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and in full.

B-656

BRAWNER

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2695

50 2695

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Lucinda Browner</i>		2. DATE OF DEATH <i>March 22/50</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>md.</i> b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor Home for the Aged</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 10-01</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <i>1200 Valley St.</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W.</i>	8. DATE OF BIRTH <i>June 1853</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <i>96</i>
11. BIRTHPLACE (State or foreign country) <i>Charles Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Schröder</i>		14. MOTHER'S MAIDEN NAME <i>Kathie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sister Ignatius</i>		ADDRESS <i>1200 Valley St.</i>	
18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Hypertensive Cardiovascular Disease -</i> DUE TO (B) <i>Arterio Sclerosis</i> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i> <i>10 yrs</i>			
19A. DATE OF OPERATION <i>0</i>			19B. MAJOR FINDINGS OF OPERATION
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Dec 1</i> , 1949, to <i>March 22</i> , 1950, that I last saw the deceased alive on <i>March 22</i> , 1950, and that death occurred at <i>4-57 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>E. G. Hall Hall M.D.</i>		23B. ADDRESS <i>1631 E North Ave</i>	23C. DATE SIGNED <i>Apr 9 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 25, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St Mary</i>
24D. LOCATION (City, town, or county) (State) <i>Govanestown Md</i>		25. FUNERAL DIRECTOR <i>Bros. Kate R Williams-Schroeder</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston H. Williams</i>	

VS 150

937



VALLEY

CONCRETE

BOND

UNION

STATE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

B-520

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2896

BIRTH NO. 50 2696 49-17967

1. NAME OF DECEASED  
(Type or Print)

JANICE

BANKS

2. DATE  
OF  
DEATH March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital, do

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

746 W. Lexington St. 6-6

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

B. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year  
Months Days Hours Min.

Female Colored

Aug. 26, 1949

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Banks.

14. MOTHER'S MAIDEN NAME

Thelma Yates.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Thelma Yates. 746 W. Lexington St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Interstitial Pneumonitis

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED

March 21, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF GEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial 3-24-1950 Mt. Auburn Cem Balto. Md.  
MAR 23 1950 Huntington, W. Va. Dr. R. Williams Schroeder







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

E-524  
50 2697

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

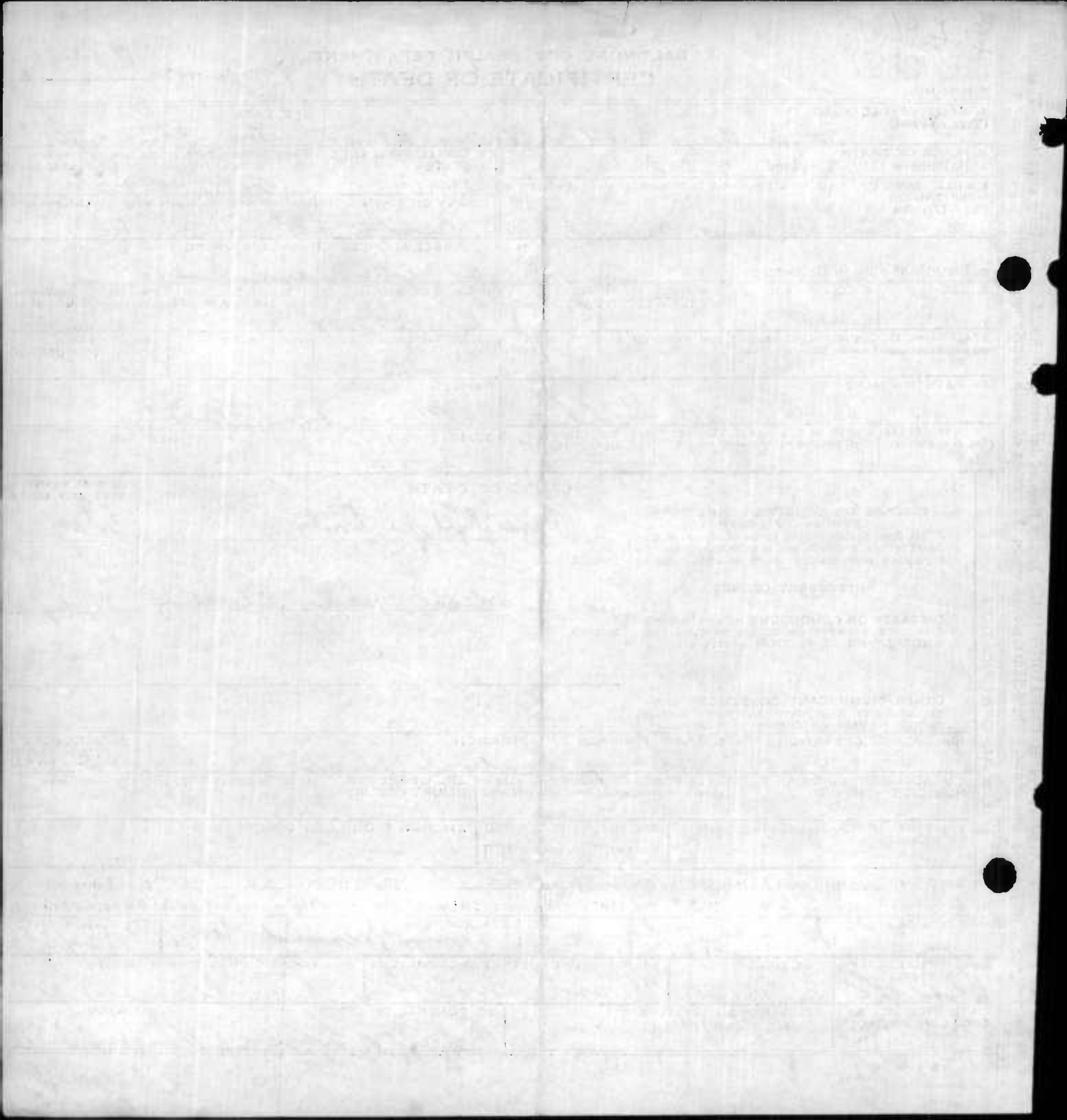
X Registered No. 50 2697

BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Engle Engelhardt, George Elmer</i>			2. DATE OF DEATH <i>3-22-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balto. City</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto - 28, CATONSVILLE</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>614 Edmondson ave.</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <i>Dec. 27, 1895</i>	9. AGE (In years last birthday) <i>64</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None SALESMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AUTO (R)</i>		11. BIRTHPLACE (State or foreign country) <i>Balto</i>	
13. FATHER'S NAME <i>Mr. Paul Engelhardt</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane Braden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>self</i>	
				ADDRESS	
18. <i>541.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pericardial peritonitis</i>			CAUSE OF DEATH (A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Duodenal ulcer, bleeding</i>			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION <i>3-14-50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Bleeding duodenal ulcer</i>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Mar 11</i> , 19 <i>50</i> , to <i>Mar 12</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-22</i> , 19 <i>50</i> , and that death occurred at <i>6:00</i> Am., from the causes and on the date stated above.					
23A. SIGNATURE <i>Mr. F. Coy 3rd</i>			23B. ADDRESS <i>Union Memorial Hosp</i>		23C. DATE SIGNED <i>3/22/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/25/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem, Woodlawn Md.</i>		24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 23 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. H. Williams, Jr.</i>		25. FUNERAL DIRECTOR <i>Easton Home Catonsville</i>	
				ADDRESS	

29869

117028, md.







correct age is especially important. Physicians: please write the causes of death clearly and fully.

520  
50 2698

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2698  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BERTHA DANCY THOMAS

2. DATE  
OF DEATH March 21, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE Maryland B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore township)

C. Length of stay in Baltimore

15 yrs.

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

321 N. Gilmore Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec 24, 1901

9. AGE (In years  
last birthday)

48

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Goldboro N. C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Barnes

14. MOTHER'S MAIDEN NAME

Phoebe Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dorothy Dancy Chase

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive arteriosclerotic  
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☐ 23C. DATE SIGNED  
M.D. MEDICAL INVESTIGATOR.....☒ March 21, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

93D 1124 N Caroline St



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

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M-365  
50 2699

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2699  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Roberto Medrano 531641

2. DATE OF DEATH

MAR 23 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Fla.

V-08

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

MIAMI

D. STREET ADDRESS (If rural, give location)

4469 Royal Palm Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

9-9-88

9. AGE (In years last birthday)

51

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or what retired)

Retired Dancer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Argentina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Medrano

14. MOTHER'S MAIDEN NAME

Mary Yisolina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 193X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GLIOMA, LEFT TEMPORAL LOBE  
DUE TO LOBE OF BRAIN

INTERVAL BETWEEN ONSET AND DEATH

1 YEAR

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

Mar 22, 1950

19B. MAJOR FINDINGS OF OPERATION

GLIOMA, LEFT TEMPORAL LOBE

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15-1950 No. 3-23-1950 that I last saw the deceased alive on 3-23-1950, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Green

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

Mar 23, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

Mar 23

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

MAR 23 1950

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR:

H. J. J. & Son Inc.

ADDRESS

Balto. Md. 54a

correct age is especially important. Physicians: please write the causes of death clearly and fully. Every item of information should be carefully supplied. The



19

ALBANY, N.Y. JANUARY 1, 1911  
OFFICE OF THE ATTORNEY GENERAL

TO THE HONORABLE SENATE AND ASSEMBLY

1910-11



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 2700**

**50 2700**

1. NAME OF DECEASED (Type or Print) <i>Margaret Tyson Patterson</i>			2. DATE OF DEATH <i>March 23, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>6000 Bellona Ave</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Edgewood Nursing Home</i>			C. CITY OR TOWN (If outside corporate limits write full name of township) <i>Baltimore</i>		
D. STREET ADDRESS (If rural, give location) <i>2900 N Calvert St</i>			E. LENGTH OF STAY IN BALTIMORE <i>Life</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>Jan 12 1879?</i>		9. AGE (In years last birthday) <i>71?</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto., Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>William Buckler Willson</i>		
14. MOTHER'S MAIDEN NAME <i>Anna Tyson</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>---</i>			17. INFORMANT <i>William Patterson 1110 Belle</i>		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary Edema</i>		
(B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerotic Cardio Vascular disease</i>		
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>					
23A. SIGNATURE <i>William J. Beltrich</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>3/23/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar. 25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto., Md</i>		25. FUNERAL DIRECTOR <i>Henry J. Jenkins &amp; Sons Co 4905 York Rd.</i>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2701  
Registered No. \_\_\_\_\_

460  
50 2701  
BIRTH NO.

1. NAME OF DECEASED (Type or Print)		ALICE S. TAYLOR		2. DATE OF DEATH MAR. 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 711 GITTINGS AVE.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. 27-08 B			
5. Length of stay in Baltimore 52 Yrs.		D. STREET ADDRESS (If rural, give location) 711 GITTINGS AVE			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT. 29, 1872	9. AGE (in years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VA. HALFAX CO.	
13. FATHER'S NAME JOHN BURTON		12. CITIZEN OF WHAT COUNTRY? U.S.		14. MOTHER'S MAIDEN NAME MARIA POWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT J. EDWARDS TAYLOR	
18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Mesenteric Thrombosis 10 days		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Atherosclerosis, general 10 yrs (C) Senility 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension 10 yrs		19A. DATE OF OPERATION None		19B. MAJOR FINDINGS OF OPERATION None	
21A. ACCIDENT WAS UNDER- Lying OR CONTRIBUTING CAUSE OF DEATH None		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY None		21E. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK None		21F. HOW DID INJURY OCCUR? None	
22. I hereby certify that I attended the deceased from 1940 to Mar 22, 1950, that I last saw the deceased alive on Mar 21, 1950, and that death occurred at 6:00 A. M., from the causes and on the date stated above.					
23A. SIGNATURE A. J. Chaffin		23B. ADDRESS 6210 York Rd		23C. DATE SIGNED Mar. 22-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-24-1950		24C. NAME OF CEMETERY OR CREMATORY LORRAINE PARK	
24D. LOCATION (City, town, or county) BALTO. CO.		24E. STATE MD.		24F. DATE RECEIVED BY LOCAL REGISTRAR MAR 23 1950	
24G. REGISTRAR'S SIGNATURE Huntington		24H. FUNERAL DIRECTOR H. W. JENKINS & SONS CO.		24I. ADDRESS 4905 YORK RD	



DR. CHALFANT  
6210 YORK RD.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2702

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mike Gazdo Jr. MICHAEL GAZDO, Jr.

2. DATE  
OF  
DEATH

March 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Agnes Hospital

Length of stay in Baltimore

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Michael Gazdo, Sr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

17. INFORMANT Mt. St. Joseph Hospital, Irvington

Brother Bartholomew

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of Bladder

10 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Papillary Carcinoma of Bladder 11 months

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

19A. DATE OF OPERATION

5/26/49

19B. MAJOR FINDINGS OF OPERATION

Papillary Carcinoma of Bladder

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/20, 1948, to 3/22, 1950, that I last saw the deceased alive on 3/21, 1950, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Stephen H. Paduano M.D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/24/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

John J. [Signature]

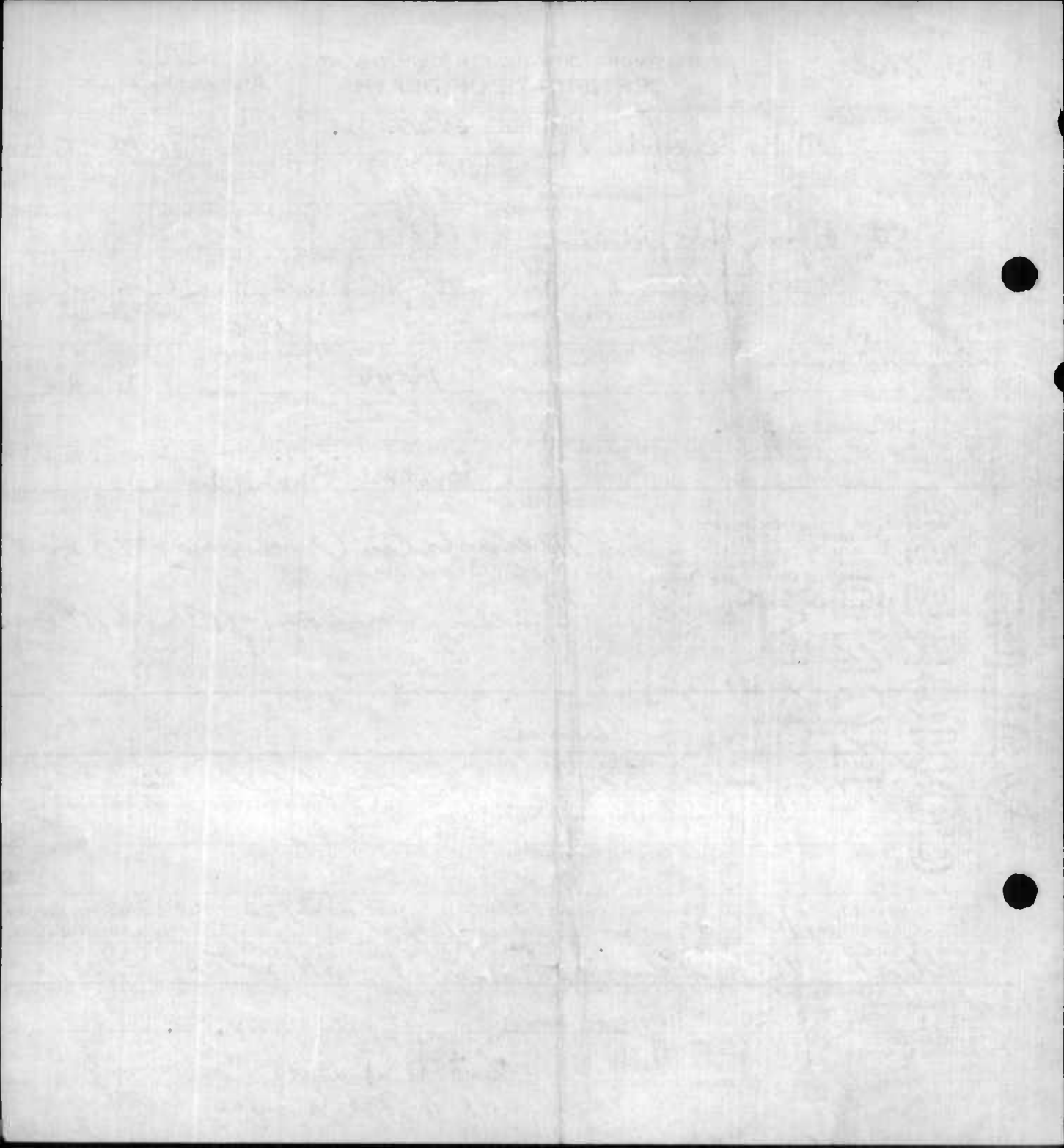
25. FUNERAL DIRECTOR

ADDRESS

Chas. J. Evans & Son, Inc.

118 N. Mt. Royal Ave.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

EMORY HULTON STILTZ

2. DATE  
OF  
DEATH

3/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE MD B. COUNTY BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
MONKTON 5300

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4/3/1884

9. AGE (In years;  
last birthday)

65

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR  
INDUSTRY

CONST.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOHN EMORY STILTZ

14. MOTHER'S MAIDEN NAME

EMMA FOSTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.  
213-18-1130

17. INFORMANT ADDRESS  
MAMIE STILTZ  
MONKTON, MD.

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

circulatory collapse

12 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

INTESTINAL OBSTRUCTION 5 days

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CARCINOMA CECUM

19A. DATE OF OPERATION

3/22/50

19B. MAJOR FINDINGS OF OPERATION

CARCINOMA OF CECUM, INTESTINAL OBSTRUCTION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/19, 1950, to 3-23, 1950, that I last saw the  
deceased alive on 3-23, 1950, and that death occurred at 5:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

R. E. HUNT

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

3/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

MARCH 26-50

24C. NAME OF CEMETERY OR CREMATORY

FOSTER'S

24D. LOCATION (City, town, or county)

HERFORD

(State)

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Williams, M.D.

ADDRESS

White Hall, Md.



CERTIFICATE OF DEATH

UNIFORMED BY HEALTH DEPARTMENT

No.

Date

Age

Place of Birth

Sex

Color

Religion

Marital Status

Education

Occupation

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Chaplain

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

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M-210

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2704

Registered No.

BIRTH NO. 136259 N.R.

1. NAME OF DECEASED (Type or Print) <b>Deborah Lynn McVey</b>			2. DATE OF DEATH <b>3-21-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Dundalk</b>		
D. STREET ADDRESS (If rural, give location) <b>2508 W. Woodwell Rd. -22</b>					
Length of stay in Baltimore <b>Life</b>		Yrs. Mos. Days	8. DATE OF BIRTH <b>Feb. 25, 1950</b>		9. AGE (In years last birthday) <b>24</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Jim McVey</b>			14. MOTHER'S MAIDEN NAME <b>Ethel Delph</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B. C. H. Records, 4940 Eastern Ave.</b>	

18. **759.31**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Multiple Congenital Defects**

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-2-50**, 19**50** to **Mar. 21**, 19**50**, that I last saw the deceased alive on **Mar. 21**, 19**50**, and that death occurred at **6.30 PM** from the causes and on the date stated above.

23A. SIGNATURE **[Signature]**

23B. ADDRESS

M. D.

**4940 Eastern Ave.**

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Cremated**

24B. DATE

**3-23-50**

24C. NAME OF CEMETERY OR CREMATORY

**B. C. H. Crematory**

24D. LOCATION (City, town, or county)

**4940 Eastern Ave.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

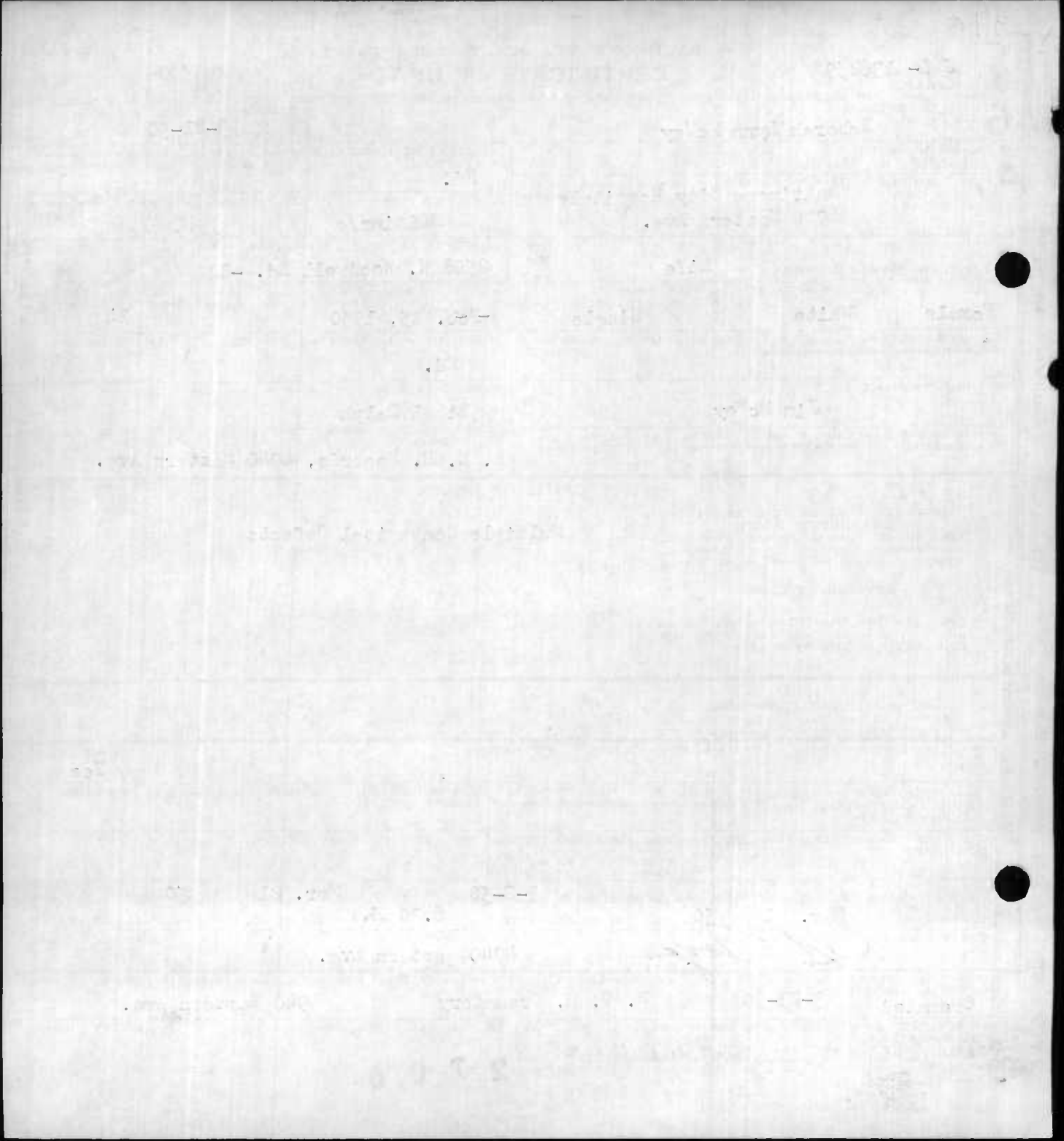
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**3/24/50****[Signature]****2706**







The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620-127723

50 2705

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2705

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Janet Gracie

2. DATE  
OF  
DEATH

3-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

14-02

D. STREET ADDRESS (If rural, give location)

Eutaw Nursing Home 1708 Eutaw Pl.

Length of stay in Baltimore

since 1944

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Practical Nurse

13. FATHER'S NAME

Michael Raddy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

June 2, 1882

9. AGE (In years last birthday)

67

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Sarah Robinson

17. INFORMANT

ADDRESS 4940

Records\*Balto. City Hospitals Eastern Ave.

18. 500.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Bronchopneumonia and pulmonary edema

(A) ~~Arteriosclerotic Heart Disease~~

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute bronchitis

DUE TO

(over)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia & Diabetic Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-22-1949, to 3-22-1950 that I last saw the deceased alive on 3-22-1950, and that death occurred at 8:46 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

3-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

3/24/50

24C. NAME OF CEMETERY OR CREMATORY

Green Mount

24D. LOCATION (City, town, or county) (State)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Bokeme. 1217 St. Paul St.



See Document File 50-2705 For corrective authorization

12/4/50

ES



50 2706

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2706

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES W. LYNCH

2. DATE  
OF  
DEATH March 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

2662 Presbury St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2662 Presbury St.

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 12, 1892

9. AGE (In years  
last birthday)

57

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Chauffeur, retired

10B. KIND OF BUSINESS OR  
INDUSTRY

John Hoos Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Lynch

14. MOTHER'S MAIDEN NAME

Cora V. Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
215-09-2215

17. INFORMANT

ADDRESS

Lula M. Lynch, 2662 Presbury St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

5 yr.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1945, to March 22, 1950, that I last saw the  
deceased alive on March 14, 1950, and that death occurred at 11 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Baltimore Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

William Cook, Inc., 1217 St. Paul St.

VS 150

420 25

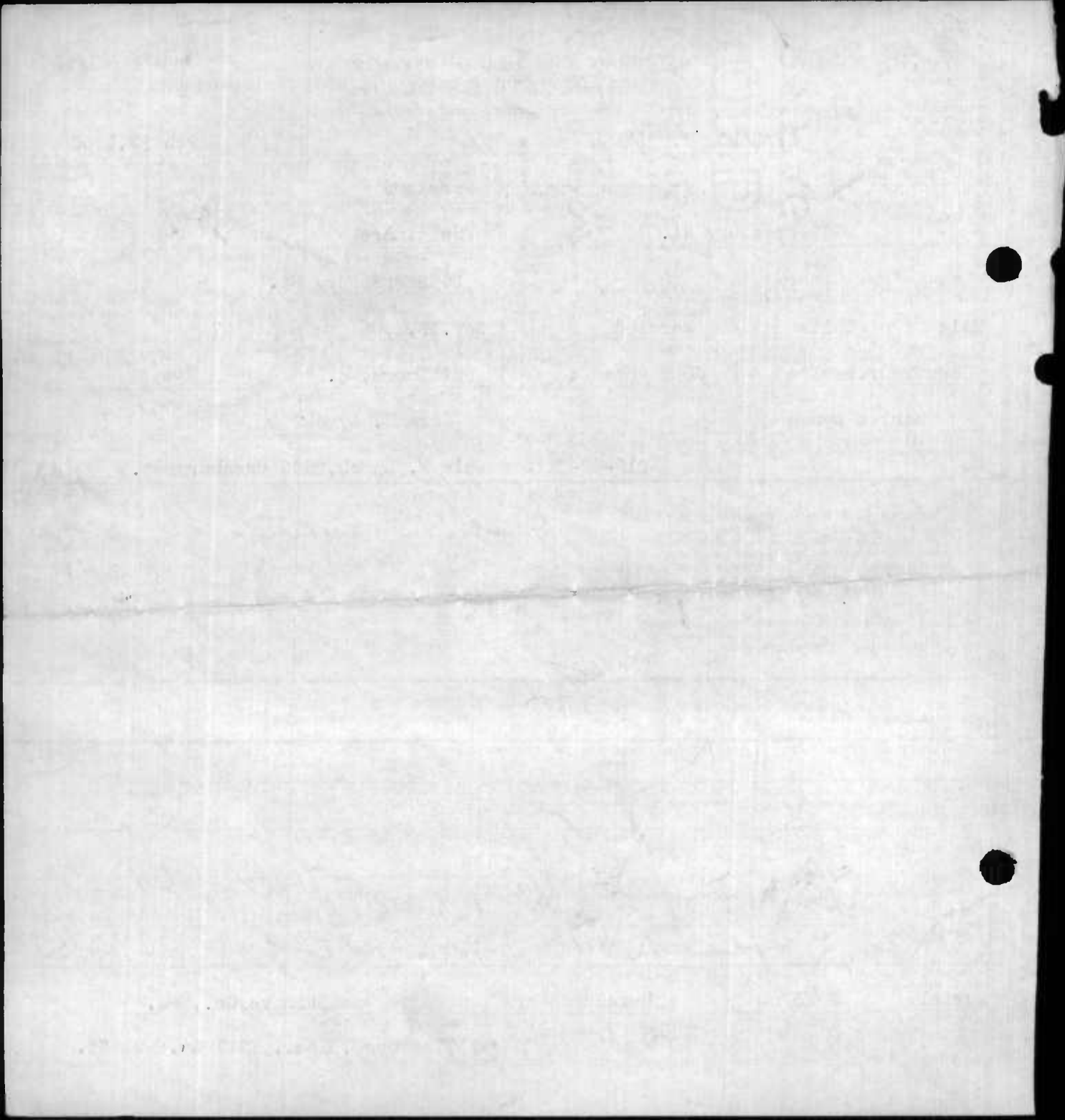
61

L-520

correct age is especially important. Every item of information should be carefully supplied. The  
physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







N-500

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

50 2707

50 2707

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>M. RAE</b> <i>Neuhan</i>			2. DATE OF DEATH <b>3-21-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. Md.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Md.</b>		
D. STREET ADDRESS (If rural, give location) <b>Sinai Hospital, Monument &amp; Br.</b>			E. Length of stay in Baltimore <b>Life</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 12, 1859</b>	9. AGE (In years last birthday) <b>90</b>	10. Under 1 Year <b>3</b> Months: <b>10</b> Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>			10B. KIND OF BUSINESS OR INDUSTRY _____		
13. FATHER'S NAME <b>Maurice Moser</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____			12. CITIZEN OF WHAT COUNTRY? <b>✓</b>		
16. SOCIAL SECURITY NO. _____			14. MOTHER'S MAIDEN NAME <b>Neuhan</b>		
17. INFORMANT <b>Mr. Wyse</b>			ADDRESS <b>Sinai Hospital</b>		

MEDICAL CERTIFICATION

18. <b>491X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Branch pneumonia</b> ANTECEDENT CAUSES <b>Memia</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Branch pneumonia</b> (B) <b>Memia</b> (C) _____	INTERVAL BETWEEN ONSET AND DEATH
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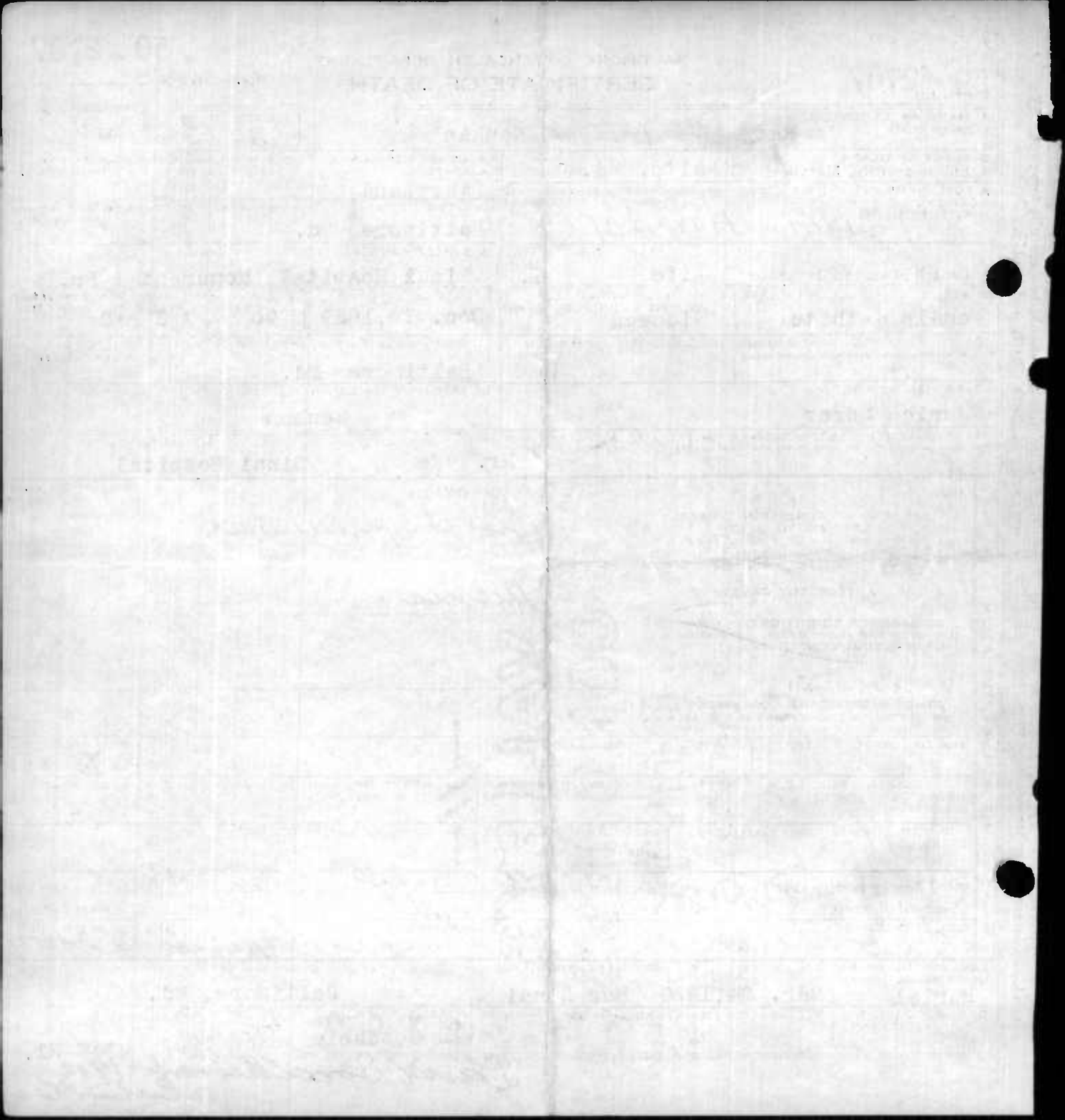
19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3-1</b> , 19 <b>50</b> , to <b>3-21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-21</b> , 19 <b>50</b> , and that death occurred at <b>10 P</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <i>Guilford Kramer</i>	23B. ADDRESS <i>Sinai Hospital</i>	23C. DATE SIGNED <b>3-21-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Mar. 24, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Har Sinai</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>	REGISTRAR'S SIGNATURE <i>William H. Williams, Jr.</i>	25. FUNERAL DIRECTOR <b>David Sondheim &amp; Son 1902 Eutaw Pl.</b>	

*David Sondheim for 1902 Eutaw Pl.*  
 107 *Eutaw Pl.*

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.



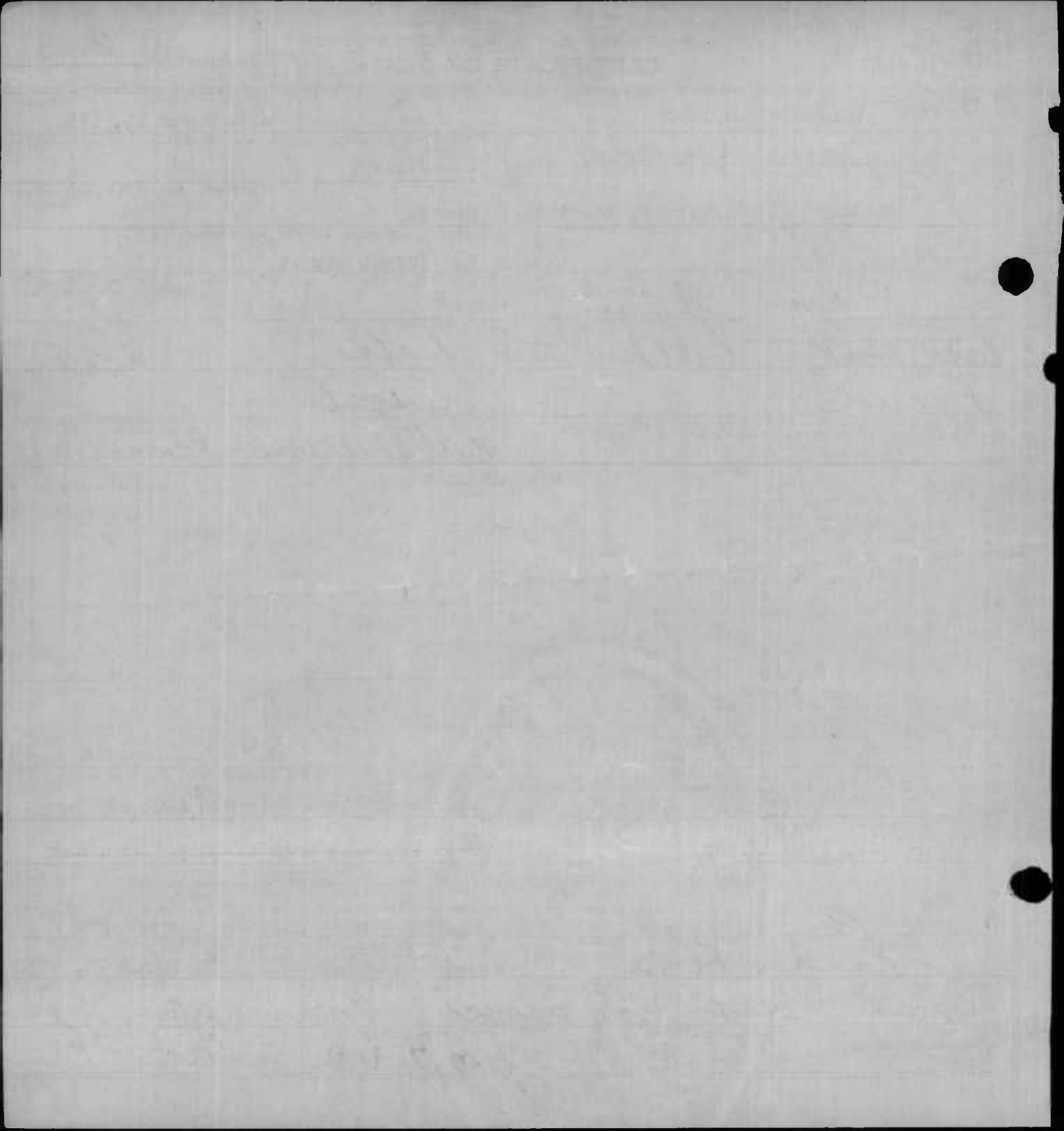




Every item of information should be carefully supplied. The cause of death clearly and briefly.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 50 2708	
BIRTH NO. 50 2708				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>GEORGE STATUES</b>			2. DATE OF DEATH <b>March 23, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland 1101 Key Highway</b> B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bethlehem Steel Shipyard Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>New Jersey</b> C. CITY OR TOWN <b>Newark</b> D. STREET ADDRESS (If rural, give location) <b>49 Vincent Street</b>		
5. SEX <b>male</b>			6. COLOR OR RACE <b>white</b>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>			8. DATE OF BIRTH <b>42</b>		
9. AGE (in years last birthday) <b>42</b>			10. Under 1 Year Months Days		
11. BIRTHPLACE (State or foreign country) <b>Lith</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank</b>			14. MOTHER'S MAIDEN NAME <b>Budget</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Michael Akiane Newark N.J.</b>		
17. INFORMANT <b>Michael Akiane</b>			ADDRESS <b>Newark N.J.</b>		
18. <b>E851</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Drowning</b> (A) DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3-24-50</b>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>shipyard</b>		
21C. WHERE DID INJURY OCCUR? <b>Bethlehem Steel Shipyard 1104 Key Hgwy.</b>			21D. HOW DID INJURY OCCUR? <b>fell from 2nd deck of ship into water</b>		
21E. TIME (Month) (Day) (Year) (Hour) <b>March 22, 1950 12.55p.m.</b>			21F. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Earl Rye</b>			23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. <b>March 23, 1950</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			24B. DATE <b>3-24-50</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>			24D. LOCATION (City, town, or county) (State) <b>North Arlington N.J.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>			25. FUNERAL DIRECTOR <b>2100 Centaur Pl</b>		
VS 151 <b>N-990</b>			<b>49664V</b>		
			<b>183</b>		







433  
50 2709

50 2709

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

DEBORAH ZLOTOWITZ

2. DATE  
OF  
DEATH

3-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Leondale

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-13

D. STREET ADDRESS (If rural, give location)

2526 Quantico Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Poland

9. AGE (In years last birthday)

47

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Samuel

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Samuel Zlotowicz 3812 Cottage Ave

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 29, 1945, to 3-23, 1950, that I last saw the deceased alive on 3-23, 1950, and that death occurred at 5 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry Nagel

23B. ADDRESS

Leondale Home

23C. DATE SIGNED

3-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-24-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county) (State)

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

Frank J. Williams

25. FUNERAL DIRECTOR

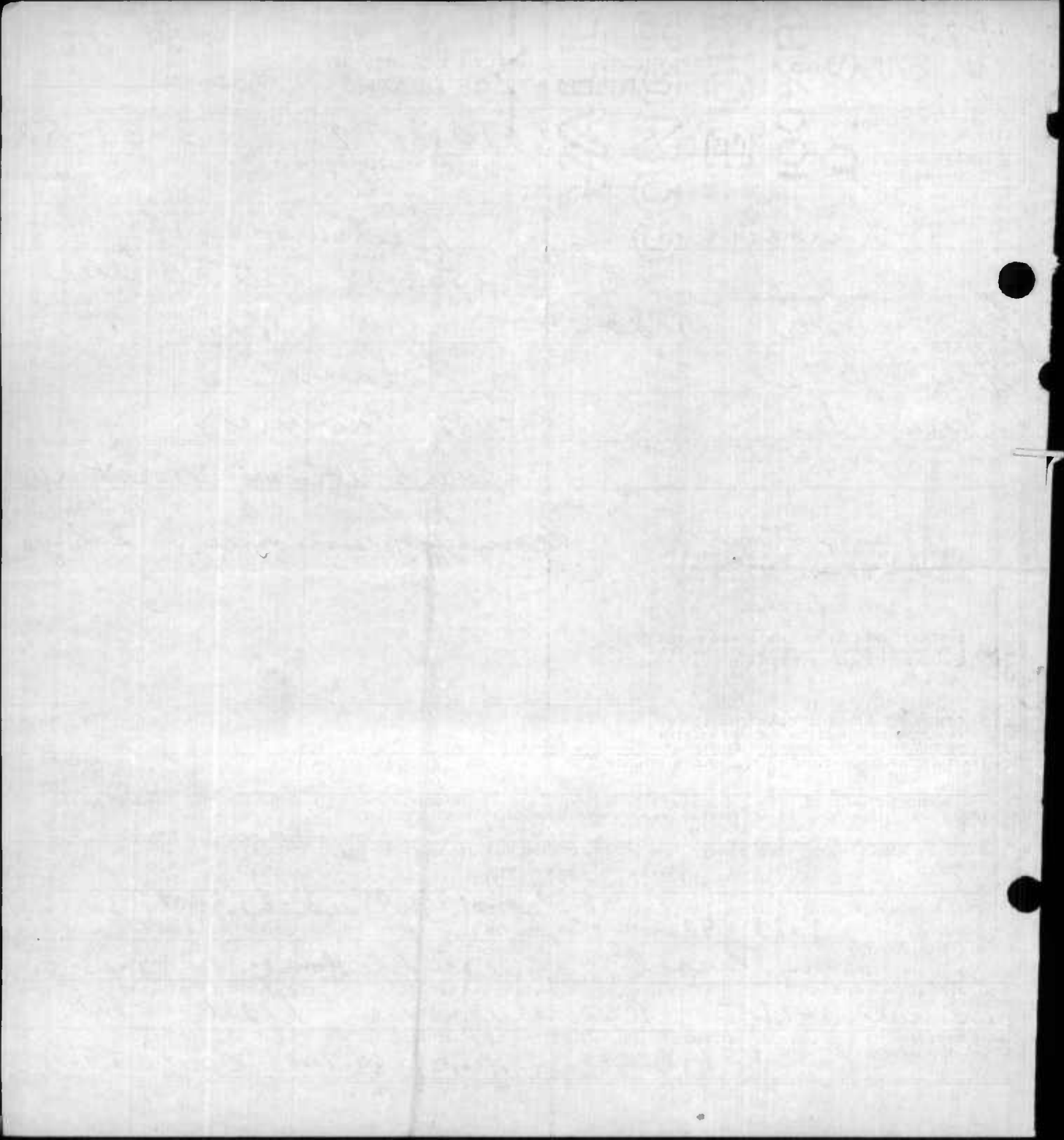
Jack Lewis 2100 Canton St

ADDRESS

MEDICAL CERTIFICATION

Physicians: please write the causes of death early and legibly.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

320

50 2710

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2710

BIRTH NO. 50-13810

1. NAME OF DECEASED  
(Type or Print)

Baby Coates

2. DATE  
OF  
DEATH

2-10-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

39

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE

MARYLAND

C. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-04

D. STREET ADDRESS (If rural, give location)

1909 Clifton Ave

C. Length of stay in Baltimore

1 day 34

Yrs.  
Mos.  
Days

5. SEX

FEMALE NEGRO

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

2-9-50

9. AGE (In years, last birthday)

11 Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Edward Coates

14. MOTHER'S MAIDEN NAME

1909 Clifton 1

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Helen Coates 1909 Clifton Ave

18. 760.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ...  
DUE TO

Massive Intracranial  
Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (a. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 2-9, 1950, to 2-10, 1950, that I last saw the  
deceased alive on 2-10, 1950, and that death occurred at 7A m., from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

M. D.

23B. ADDRESS

1422 E. Chase St

23C. DATE SIGNED

2/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL MAR 16 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

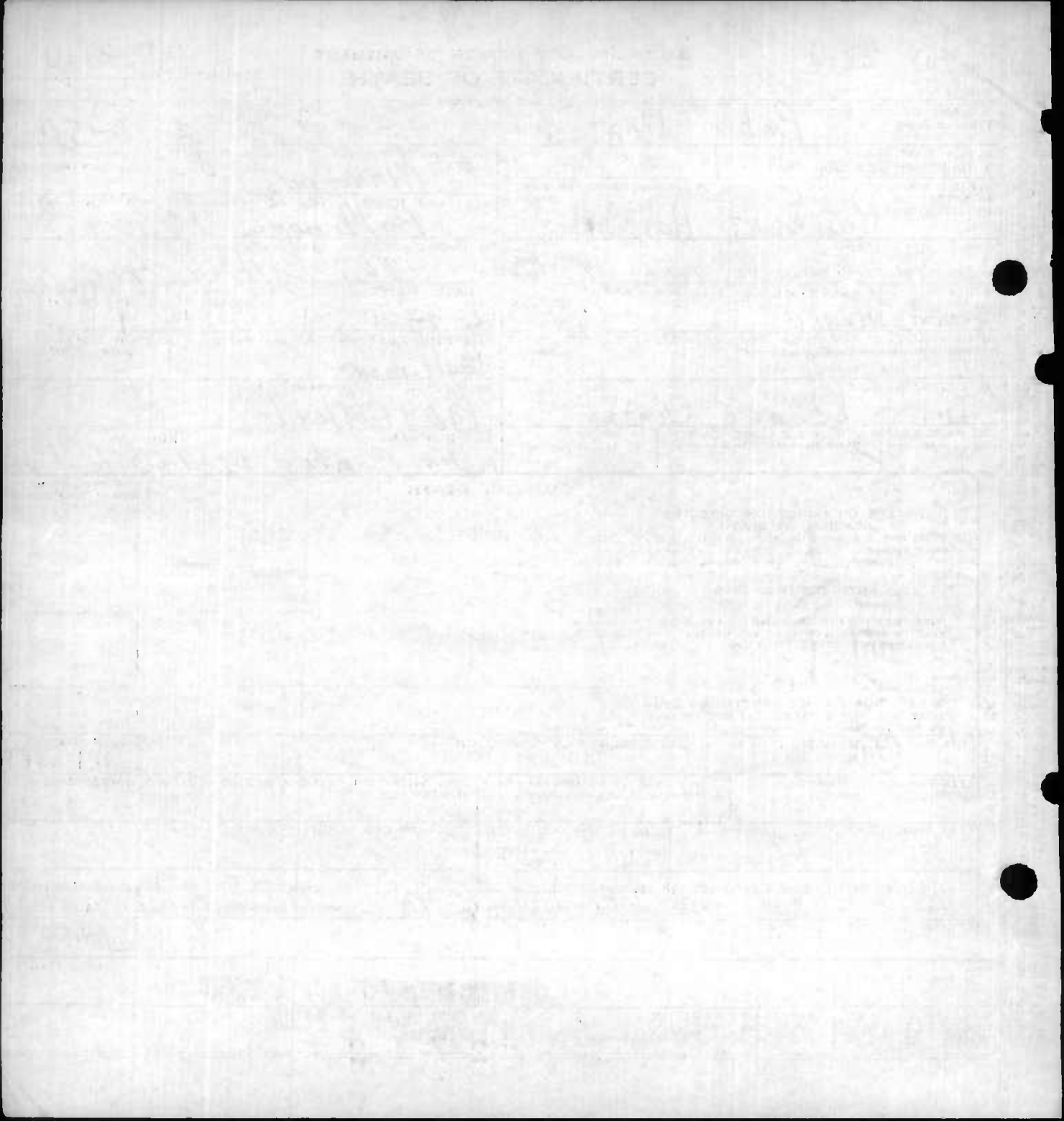
[Signature]

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0-626 50 2711

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2711

BIRTH NO. 50-03407		1. NAME OF DECEASED (Type or Print) MAUREEN PARKER		2. DATE OF DEATH 2-12-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03			
c. Length of stay in Baltimore 2		D. STREET ADDRESS (If rural, give location) 2333 Division St.			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 2-10-50	9. AGE (In years, last birthday) 2	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Paul Parker		14. MOTHER'S MAIDEN NAME Eva Ruth Sprague			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mother ADDRESS 2333 Division St.		
18. 760.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prolonged Cerebral Hypoxia		CAUSE OF DEATH (A) DUE TO Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-10-1950, to 2-12-1950, that I last saw the deceased alive on 2-12-1950, and that death occurred at 2:30 a. m., from the causes and on the date stated above.					
23A. SIGNATURE W. L. Lewis Young		23B. ADDRESS 1100 Dund Hill Cr.		23C. DATE SIGNED 2/17/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25. FUNERAL DIRECTOR Commissioner of Health		ADDRESS			

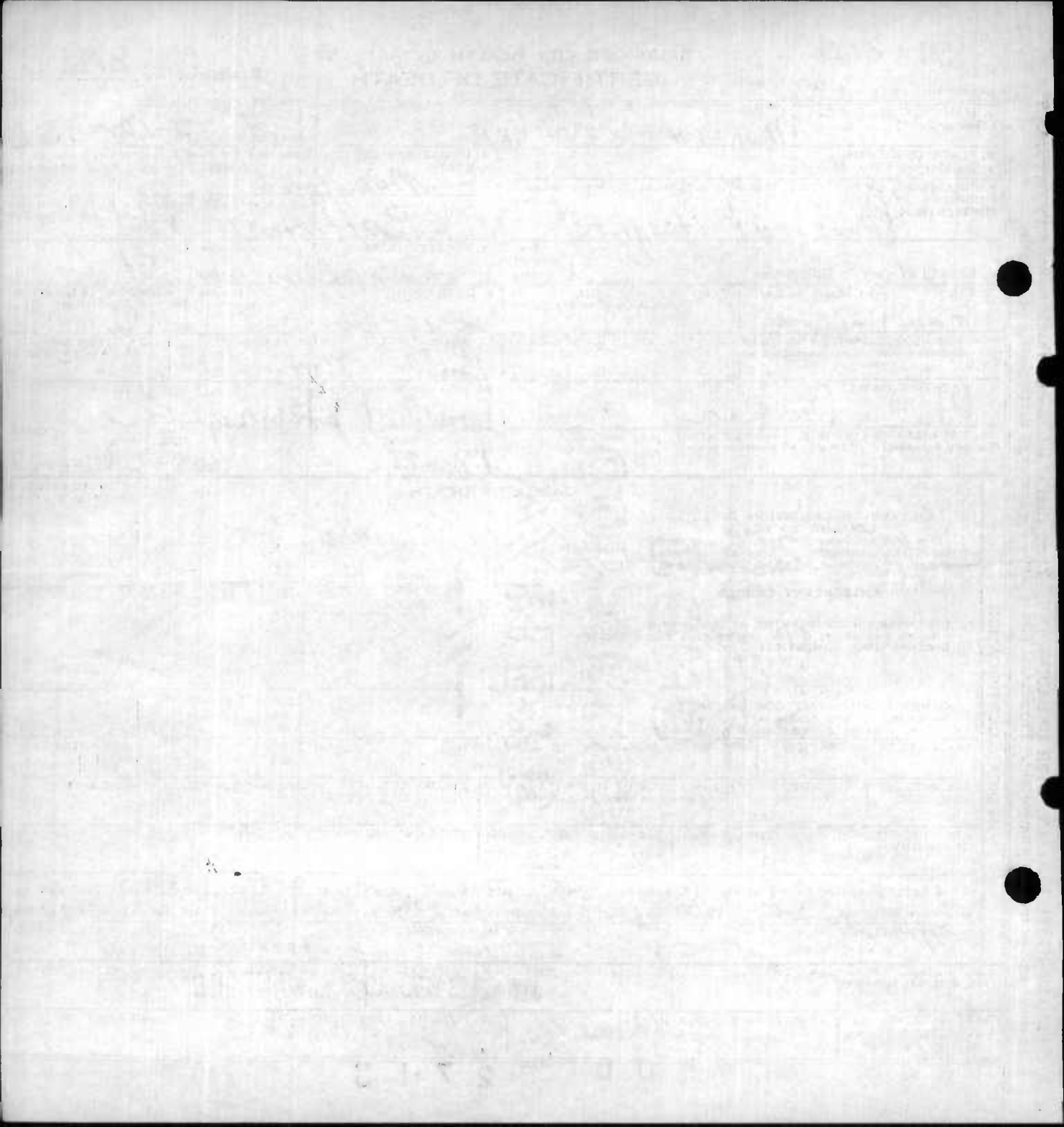
JOHN HOPKINS MEDICAL SCHOOL MAR 16 1950

VS 150

5000027113

159





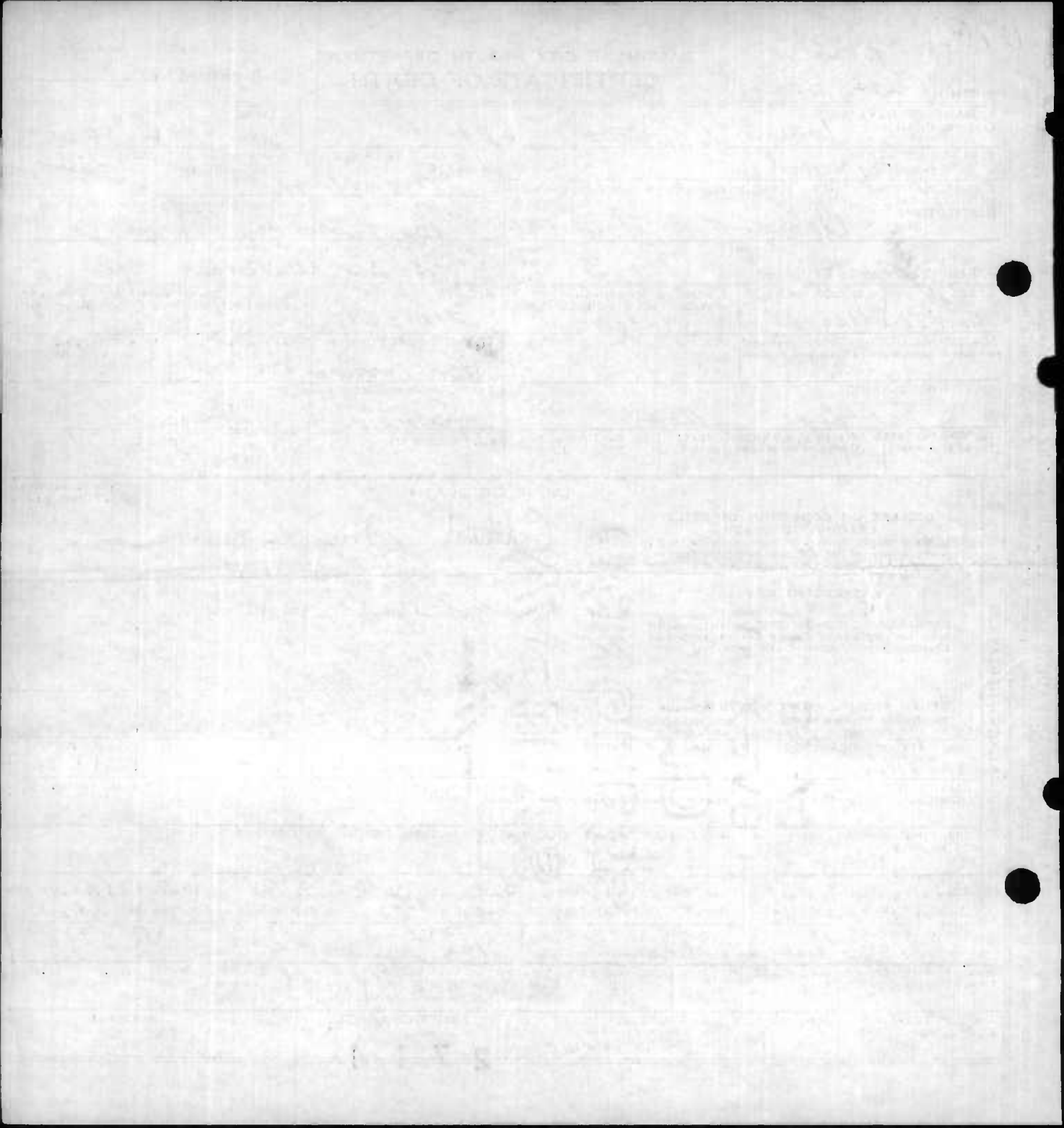


PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

BALTIMORE CITY HEALTH DEPARTMENT				50 2712	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. 50-05548		1. NAME OF DECEASED (Type or Print) <i>Janice NANETTE LEE</i>		2. DATE OF DEATH <i>3/14/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-04</i>			
C. Length of stay in Baltimore <i>3</i> Days		D. STREET ADDRESS (If rural, give location) <i>2132 Walbrook Ave.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Infant</i>	8. DATE OF BIRTH <i>3/11/50</i>	9. AGE (In years last birthday) If Under 1 Year: Months: Days <i>3</i> If Under 24 Hours: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>T. Tolford LEE</i>		14. MOTHER'S MAIDEN NAME <i>Georgiana Dunaway</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>mother</i>	
18. <i>7600</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Edema</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Phos. 66</i> <i>Traumatic injury of the head</i>		DUE TO (A) (B) (C) <i>Anoxia of the Brain</i> <i>Lues</i> <i>Treated patient</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/11/50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Low cervical cancer section</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/11</i> 19 <i>50</i> , to <i>3/14</i> 19 <i>50</i> , that I last saw the deceased alive on <i>3/14</i> 19 <i>50</i> , and that death occurred at <i>1:50</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>N. Louis Foremy</i>		23B. ADDRESS <i>1124 Davis Hill Ave</i>		23C. DATE SIGNED <i>3/15/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>JOHN HOPKINS MEDICAL SCHOOL</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 24 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Williams, Jr.</i>		24D. LOCATION (City, town, or county) (State) <i>MAR 16 1950</i>	
VS 150		25. FUNERAL DIRECTOR OR ADDRESS		<i>Commissioner of Health</i> <i>2714</i>	

160c







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and briefly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50-03067

1. NAME OF DECEASED  
(Type or Print)

Baby Vaughn

2. DATE  
OF  
DEATH

2-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-04

C. Length of stay in Baltimore

10 hrs

D. STREET ADDRESS (If rural, give location)  
1134 N. Monroe St.

5. SEX

m

6. COLOR OR RACE

negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
new born

8. DATE OF BIRTH

2-2-50

9. AGE (In years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.  
10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harold Albert Hicks

14. MOTHER'S MAIDEN NAME  
Armita Virginia Vaughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or no known) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT  
Mother

ADDRESS  
1134 N. Monroe St.

18. 760.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
DUE TO

Intracranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO

Prematurity

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
DUE TO

Drug toxicity

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2, 1950, to 2-2, 1950, that I last saw the deceased alive on 2-2-50, 1950, and that death occurred at 7:30 pm., from the causes and on the date stated above.

23A. SIGNATURE

John A. Hicks

23B. ADDRESS

M. D.

Provident Hosp

23C. DATE SIGNED

2/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

JOHN HOPKINS MEDICAL SCHOOL MAR 17 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

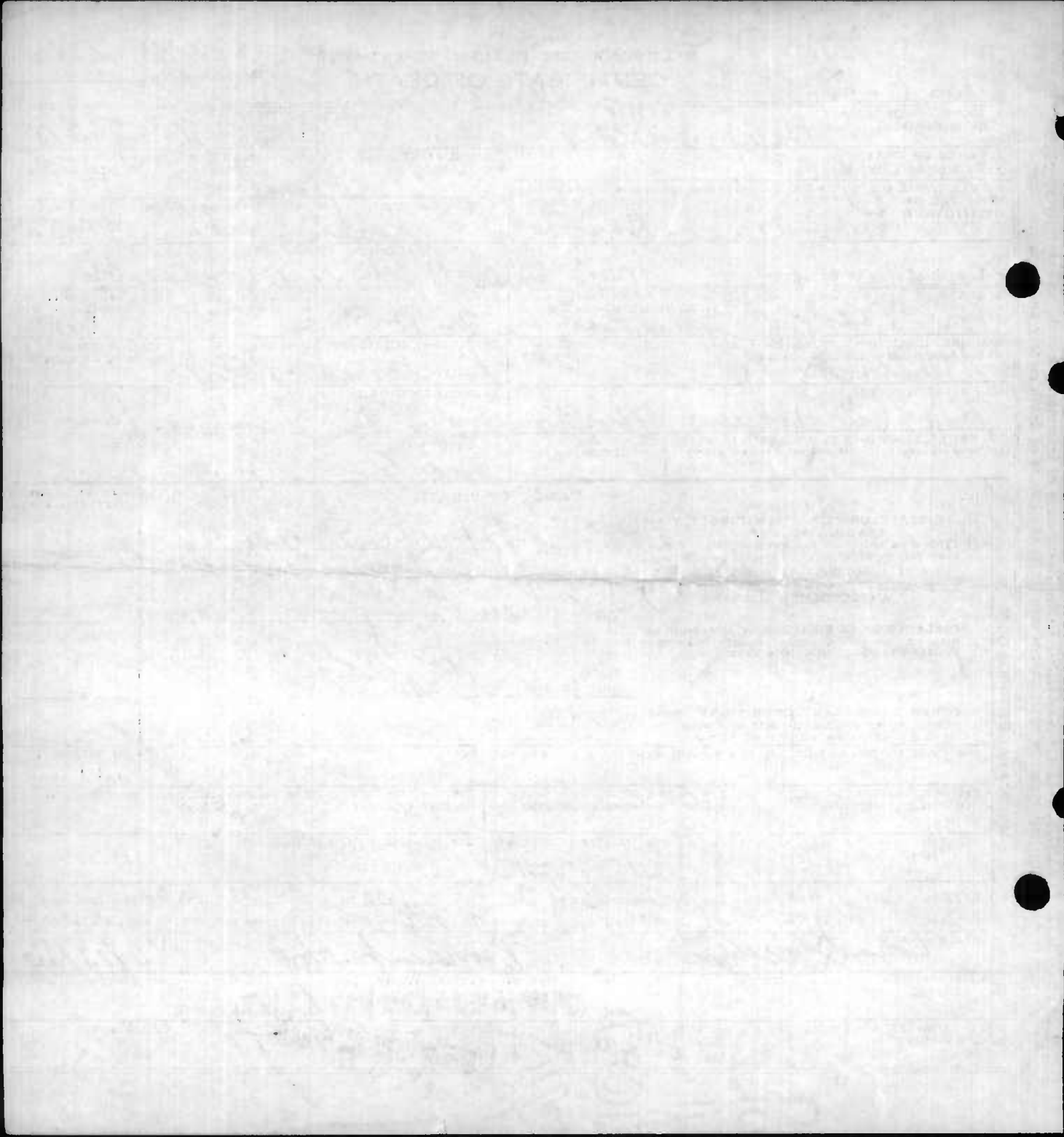
Amington H. Aliquie

Commissioner of Health

VS 150

160a

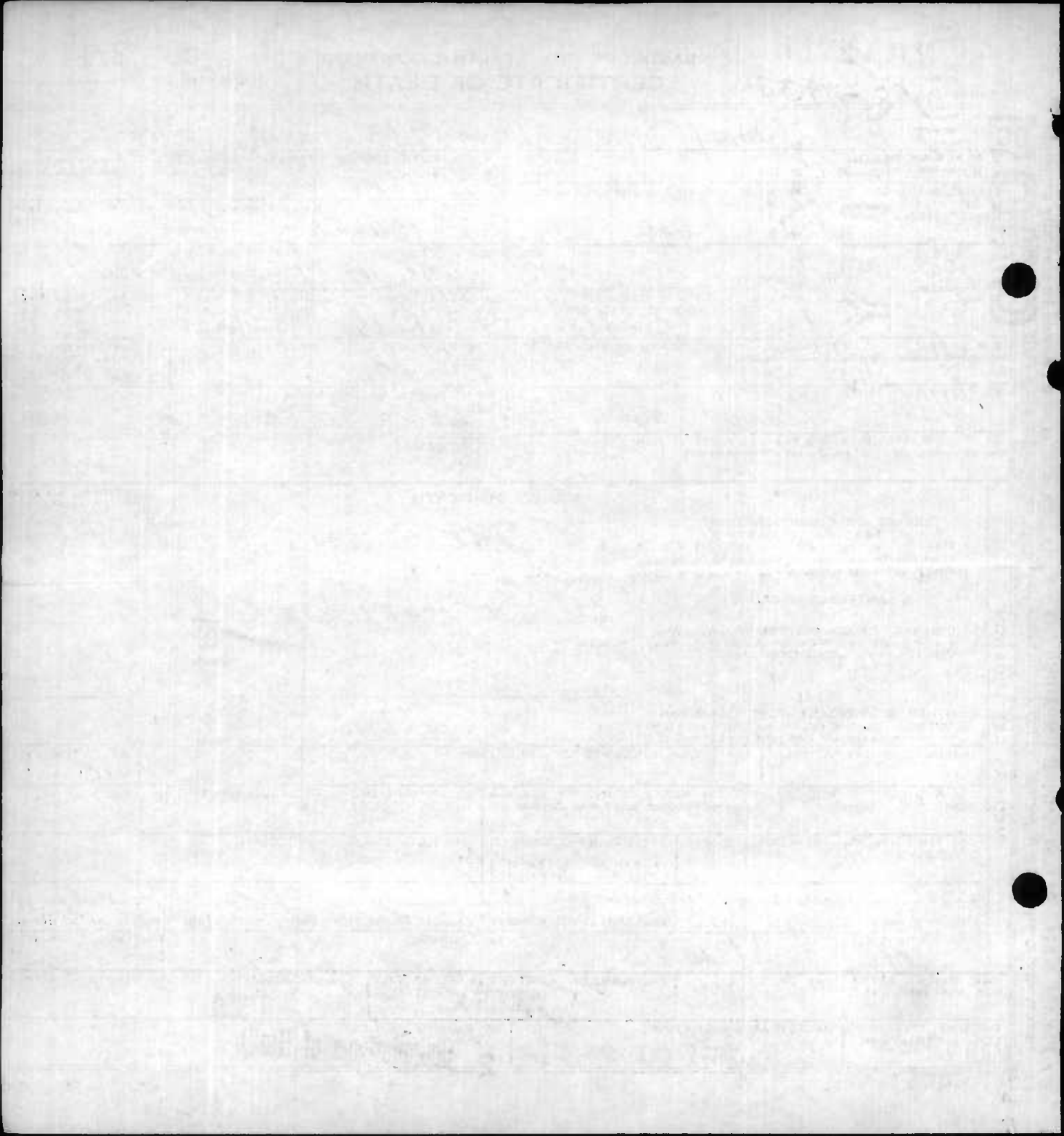














correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

520  
50 2715

50 2715

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-05317

1. NAME OF DECEASED  
(Type or Print)

Baby Girl Jones

2. DATE  
OF  
DEATH

3-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

38 University Hosp.

C. Length of stay in Baltimore

2

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3-11-50

9. AGE in years  
last birthday

10. Under 1 Year  
Months: Days: Min.

2

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Clasworth Barnes Levi

14. MOTHER'S MAIDEN NAME

Brothy Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother

Same

18. 759.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Immature respiratory Center

DUE TO

ANTECEDENT CAUSES

(B)

Prematurity

2 days

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-11, 1950 to 3-13, 1950, that I last saw the deceased alive on 3-13, 1950 and that death occurred at 8:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Edwin M. Hubbard

M. D.

23B. ADDRESS

Univ. Hosp Balto

23C. DATE SIGNED

3-13-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL MAR 20 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

50 2716

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2716

BIRTH NO.

50-06209

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Urban

2. DATE  
OF  
DEATH

March 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Hosp. for Women of Ind.

C. Length of stay in Baltimore

7

Yes.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

March 23, 1950

9. AGE (In years  
last birthday)

10 Under 1 Year  
Months; Days

11 Under 24 Hours  
Hours; Min.

1 2

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Charles Francis Urban

14. MOTHER'S MAIDEN NAME

Bernardette Mary Wilkens

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Mrs. Charles F. Urban

ADDRESS

3539 Juneway  
Baltimore - 18

18.

761.5

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Extreme prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Premature labor

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Partial premature Separation of placenta

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 3-23, 1950 to 3-23, 1950 that I last saw the  
deceased alive on 3-23, 1950, and that death occurred at 400 a.m., from the causes and on the date stated above.

23A. SIGNATURE

William B. Spencer, Jr. M.D.

23B. ADDRESS

Hosp. for Women of Ind.

23C. DATE SIGNED

3-24-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3-24-50

24C. NAME OF CEMETERY OR CREMATORY

Holy BED.

24D. LOCATION (City, town, or county)

CITY

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

Wilmington, Delaware

25. FUNERAL DIRECTOR

ADDRESS

WIEDEFELD & SON



\_\_\_\_\_



The correct age is especially important. Physicians: please write the causes of death clearly and fully.

5050 2717

50 2717

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 58-05241

1. NAME OF DECEASED  
(Type or Print)

BABY MCGOWAN

2. DATE  
OF  
DEATH

March 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits write RURAL and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1638 Lorman Court

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

March 15, 1950

9. AGE (in years  
last birthday)

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Unknown

Unknown

18. 754.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Carl H. Boyer

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

March 15, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL MAR 22 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

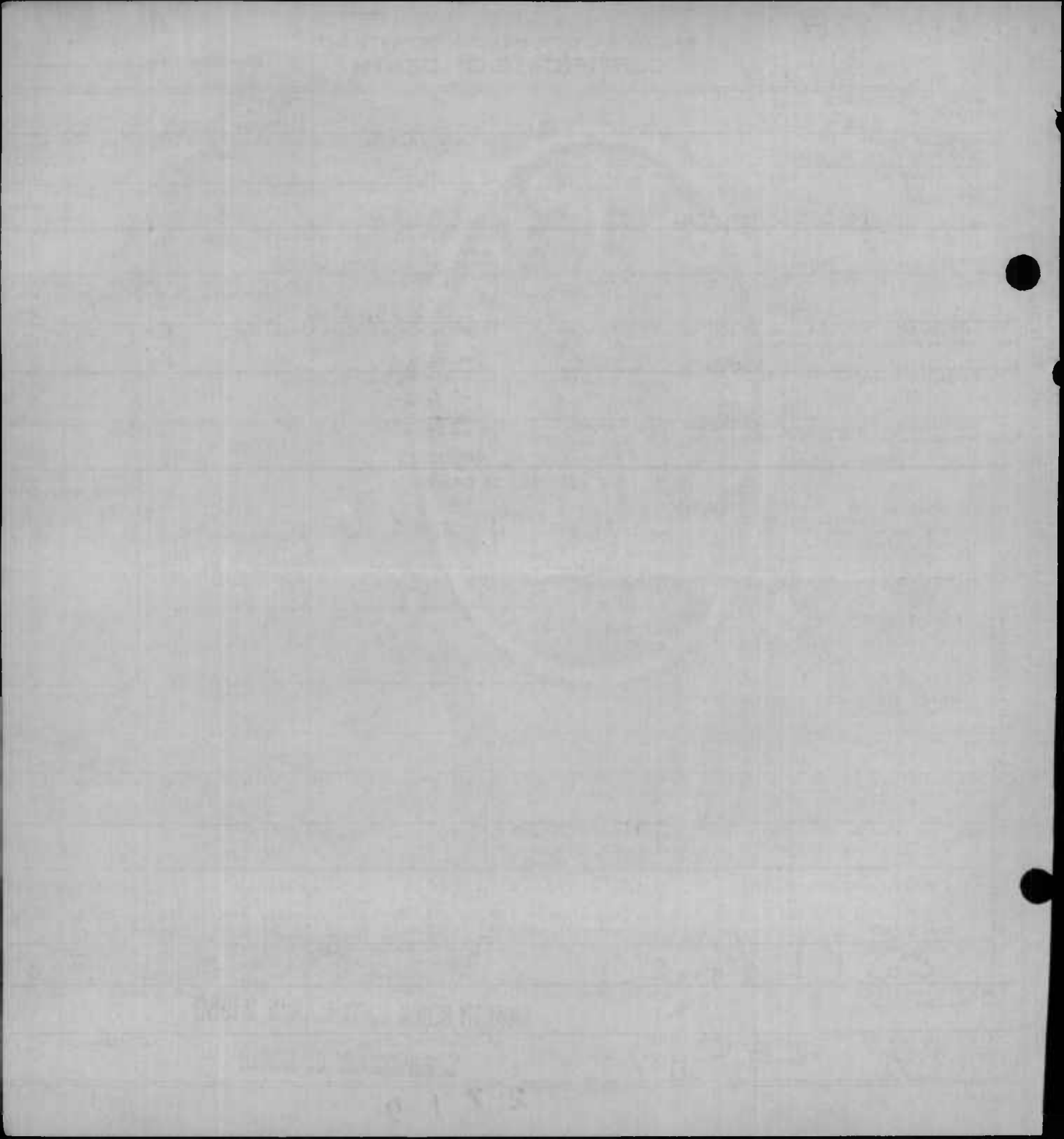
25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health

MAR 24 1950







530  
50 2718BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2718

BIRTH NO. 50-06252

1. NAME OF DECEASED  
(Type or Print)

Knott Baby Girl

2. DATE  
OF  
DEATH

March 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Church Home &amp; Hosp.

C. Length of stay in Baltimore

8 hrs 14 min

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Mr. John Knott

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

March 20, 1950

9. AGE (In years,  
last birthday)10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

8 14

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Jean Foster

17. INFORMANT

ADDRESS

Mr. John Knott 1350 Rayleigh Way

18. 7625

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Atalectasis of newborn 2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

DUE TO

(C)

Prematurity

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 20, 1950, to March 21, 1950, that I last saw the  
deceased alive on March 21, 1950, and that death occurred at 12:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Donald H. Heston, M.D.

23B. ADDRESS

Church Home &amp; Hosp.

23C. DATE SIGNED

3-21-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

MAR 24 1950

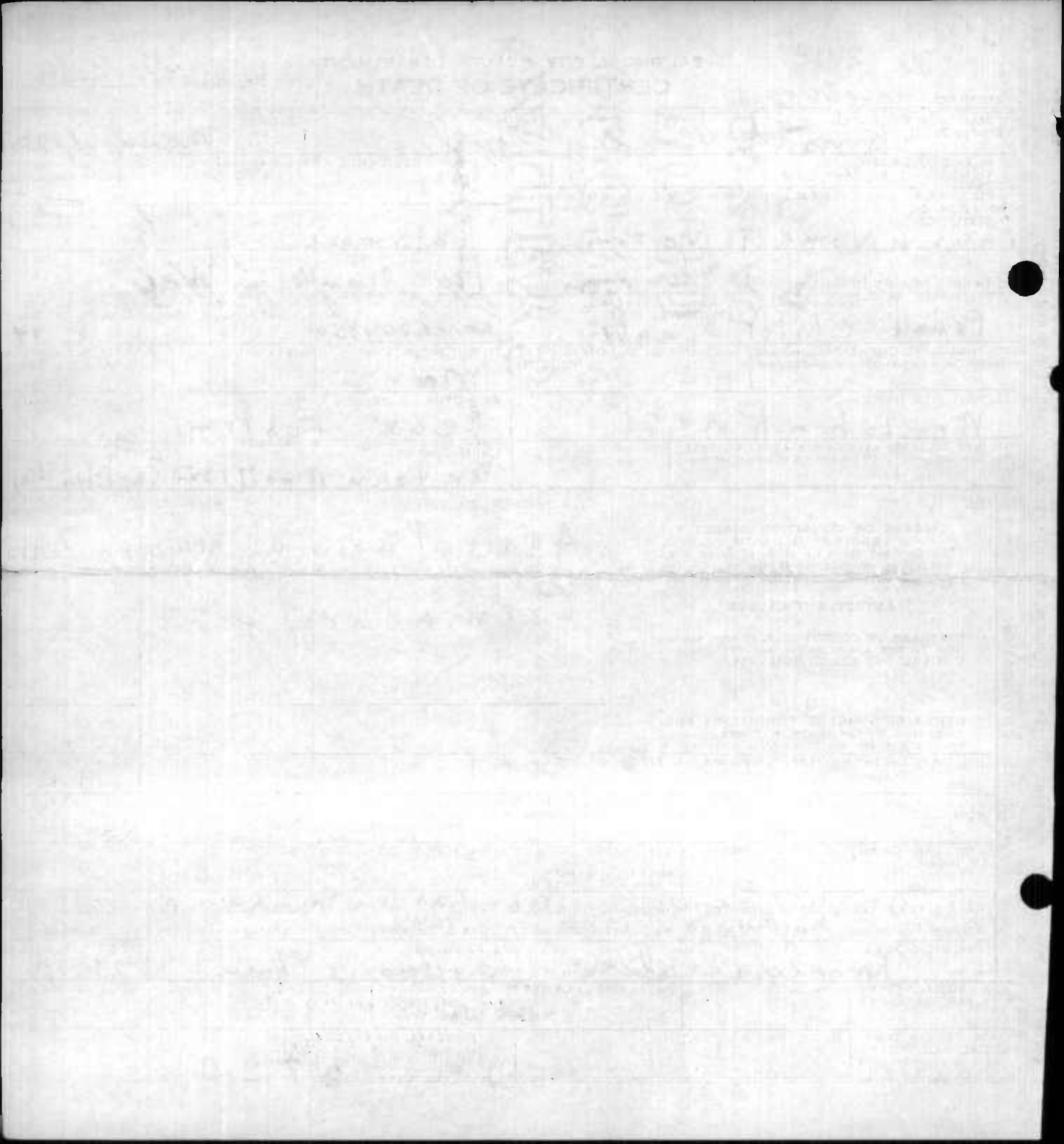
VS 150

J. HOPKINS MEDICAL SCHOOL MAR 22 1950

2720

159







correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE CLEARLY IN INK. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2719

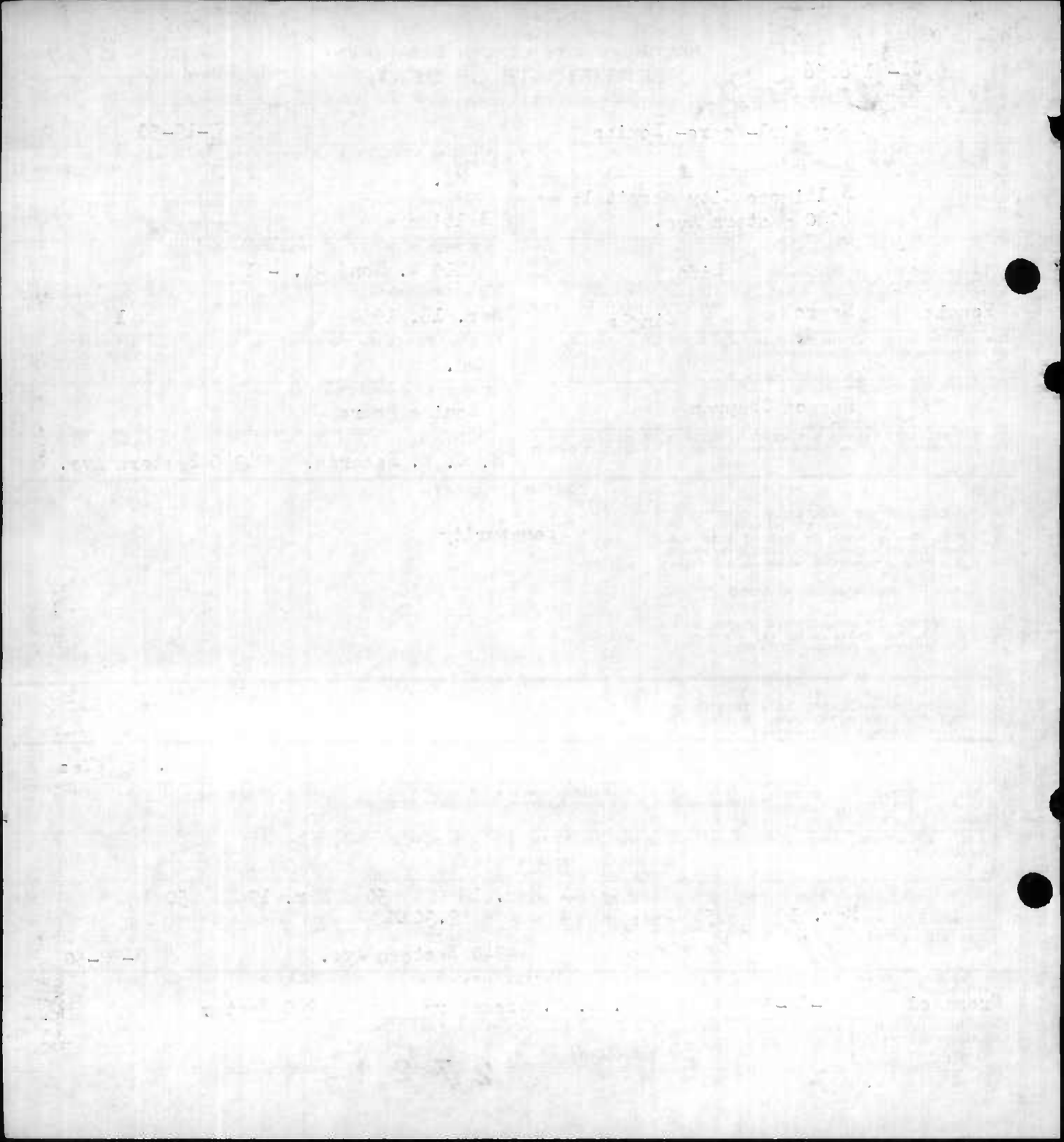
BIRTH NO. 136656  
50-2719-85499

1. NAME OF DECEASED (Type or Print) <b>Baby Girl-Moore- Louise</b>			2. DATE OF DEATH <b>3-19-50</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>3-01</b>		
6. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>119 S. Bond St. -31</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Mar. 18, 1950</b>	9. AGE (In years last birthday)	If Under 1 Year Months: <b>1</b> Days: <b>1</b> If Under 24 Hours Hours: <b>1</b> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Harmon Chapman</b>			14. MOTHER'S MAIDEN NAME <b>Louise Moore</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>B. C. H. Records,</b>			ADDRESS <b>4940 Eastern Ave.</b>		

18. <b>776. X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Prematurity</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Prematurity</b> DUE TO DUE TO DUE TO	INTERVAL BETWEEN ONSET AND DEATH
--	--	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Mar. 18</b> , 19 <b>50</b> to <b>Mar. 19</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Mar. 19</b> , 19 <b>50</b> , and that death occurred at <b>9.30AM</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>W. Rogers</b> M. D.		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>3-22-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>		24B. DATE <b>3-22-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>B. C. H. Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>4940 Eastern</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>			
24F. REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>		25. FUNERAL DIRECTOR		ADDRESS	



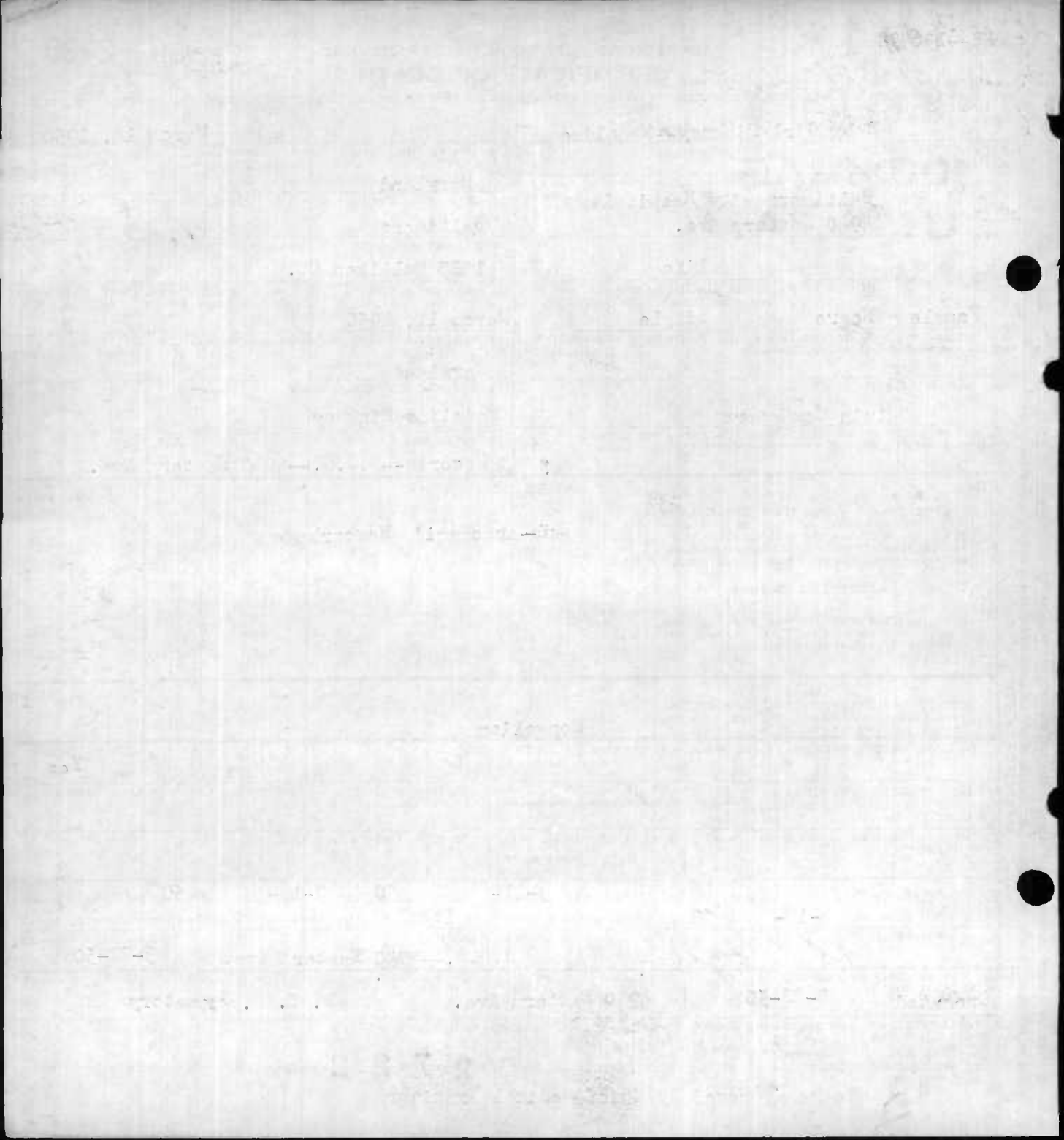




MS-136494		BALTIMORE CITY HEALTH DEPARTMENT		50 2720	
50 2720		CERTIFICATE OF DEATH		Registered No.	
BIRTH NO. 50-04975					
1. NAME OF DECEASED (Type or Print) Baby Girl Pinkney--Madeline			2. DATE OF DEATH March 18, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
6. Length of stay in Baltimore life			D. STREET ADDRESS (If rural, give location) 1523 Mulliken Ct.		
5. SEX Female		6. COLOR OR RACE Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH March 11, 1950		9. AGE (In years last birthday) 7		10. Under 1 Year Months: 7	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Calvin Commodore	
14. MOTHER'S MAIDEN NAME Madeline Pinkney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records--B.C.H.--4940 Eastern Ave.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Sub-arachnoid Hemorrhage DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mongolism		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-11-1950, to 3-18-1950, that I last saw the deceased alive on 3-18-1950, and that death occurred at 1:30 P.m., from the causes and on the date stated above.					
23A. SIGNATURE P. S. Rogers		23B. ADDRESS B.C.H.--4940 Eastern Ave.		23C. DATE SIGNED 3-22-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated		24B. DATE 3-22-50		24C. NAME OF CEMETERY OR CREMATORY 4940 Eastern Ave.	
24D. LOCATION (City, town, or county) B. C. H. Crematory		24E. DATE RECEIVED BY LOCAL REGISTRAR MAR 24 1950		24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. VS 150	
To Be Approved By Chief Medical Examiner					

160a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 2721

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

McDERMOTT

2. DATE  
OF DEATH March 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

210 E. 20th Street

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

U

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

N

13. FATHER'S NAME

N

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

W

16. SOCIAL SECURITY NO.

N

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

210 E. 20th Street

8. DATE OF BIRTH

U

9. AGE (in years last birthday)

65(?)

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

O

17. INFORMANT

N

ADDRESS

18. 4/20-1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

3-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



CERTIFICATE OF DEATH

1900-1901  
PAGE 400 1 400



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Monroe Anderson

2. DATE  
OF  
DEATH

March 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 480 X 1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Pneumonia

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Influenza

1 wks.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Cardiovascular renal disease

Unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 9, 1950, to March 10, 1950, that I last saw the deceased alive on March 10, 1950, and that death occurred at 3:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

H. Garland Whissell

M. D. 902 W. Franklin

3-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

Huntington Williams

Commissioner of Health

VS 150

131a

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2722  
Registered No.

UNIVERSITY MEDICAL SCHOOL MAR 16 1950







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2723

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM MILLS

2. DATE  
OF  
DEATH

March 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

662 Bradley Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (in years last birthday)

68

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MARRIAGE NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

N

17. INFORMANT

W

ADDRESS

N

18. 4 yr. 1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro thrombosis due to

~~arteriosclerotic~~ arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*C. J. Sullivan*

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

3/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

*Wm. J. Sullivan*

2 Commissioner of Health



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Sex		Race	
Marital Status		Cause of Death	
Occupation		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-26438

1. NAME OF DECEASED  
(Type or Print)

MITCHELL

TOWSON

2. DATE  
OF  
DEATH

2-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

2038 W. Lanvale St.

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

U

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

3 months

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. 754.4

Congenital

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Endocardial fibro-elastosis

DUE TO

ANTECEDENT CAUSES

(B)

Upper Respiratory Infection

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ ND ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Boyer

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED  
2-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington

25. FULL-TIME REGISTRAR

Commissioner of Health

ADDRESS

UNIVERSITY MEDICAL SCHOOL MAR 13 1950



elastosis =

Degeneration of elastic tissue



PLEASE WRITE PLAINLY. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

TUCKER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Charles Tucker*

2. DATE  
OF DEATH *March 5, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

*South Baltimore General Hospital*

C. Length of stay in Baltimore

*Unknown*

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*C*

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

*Unknown*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

*UNKNOWN*

*UNKNOWN*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*UNKNOWN*

16. SOCIAL SECURITY NO.

17. INFORMANT

*UNKNOWN*

ADDRESS

18. *4 yr. 1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Chronic Congestive Heart Failure*  
*Arterio-sclerotic C. V. Disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Emil H. Royer*

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED *5 Mar 50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*UNIVERSITY MEDICAL SCHOOL MAR 13 1950*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 24 1950*

REGISTRAR'S SIGNATURE

*Washington, D.C.*

25. FUNERAL DIRECTOR

*2 Commissioner of Health*

ADDRESS



CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Date of death: *10/15/1950*  
3. Place of death: *Home*  
4. Cause of death: *Heart Disease*  
5. Age at death: *75*  
6. Sex: *Male*  
7. Race: *White*  
8. Marital status: *Married*  
9. Occupation: *Teacher*  
10. Signature of physician: *[Signature]*  
11. Signature of registrar: *[Signature]*  
12. Date of registration: *10/20/1950*

13. Name of informant: *John Doe*

14. Address of informant: *123 Main St.*



352

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2726

50 2726

Registered No.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH WHITING</b>			2. DATE OF DEATH <b>Mar. 22, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-03</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1820 Etting St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>1820 Etting St.</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>odd jobs</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>John Whiting</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Brooks</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>M's Catherine Whiting 1820 Etting St</b>		

18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Stomach</b>			INTERVAL BETWEEN ONSET AND DEATH <b>History indefinite</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 10, 1950</b> , to <b>March 22, 1950</b> , that I last saw the deceased alive on <b>March 22, 1950</b> , and that death occurred at <b>11:40 P. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>D. Garland Churchill</b>		23B. ADDRESS <b>1534 Druid Hill Ave.</b>		23C. DATE SIGNED <b>March 23, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-26-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Gloucester Field Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Gloucester Co., Va.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams</b>	25. FUNERAL DIRECTOR <b>(Mrs) Frances A. Hensley</b> ADDRESS <b>578 W. Biddle St.</b>		

98899

46B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH

WATERBURY

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900



correct age is especially important. Physicians write the causes of death clearly and legibly. The

FOR APPROVAL BY MED. EXAMINER

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MRS. JOSEPHINE BARRETT

2. DATE  
OF  
DEATH

3-23-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

ST. Agnes Hospital

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR or RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

13. FATHER'S NAME

George Seymour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

none

16. SOCIAL SECURITY NO.

none

8. DATE OF BIRTH

Aug. 25, 1877

9. AGE (In years last birthday)

72

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Mexico

12. CITIZEN OF WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Josephine Gonzales

17. INFORMANT

Mr. Lester L. Barrett 1001 Francis Ave.

ADDRESS

Relay 27

18. E962.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO DUE TO HYPERTENSIVE

ANTECEDENT CAUSES

ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) FRACTURE RIGHT HIP

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

Emil Rye

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

BALT -

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

2/23/50

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

FELL GETTING OUT OF BED

22. I hereby certify that I attended the deceased from 2/23, 1950, to 3/23, 1950, that I last saw the deceased alive on 3/23, 1950, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John H. Shaw

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

3/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

Wilmington, Delaware

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

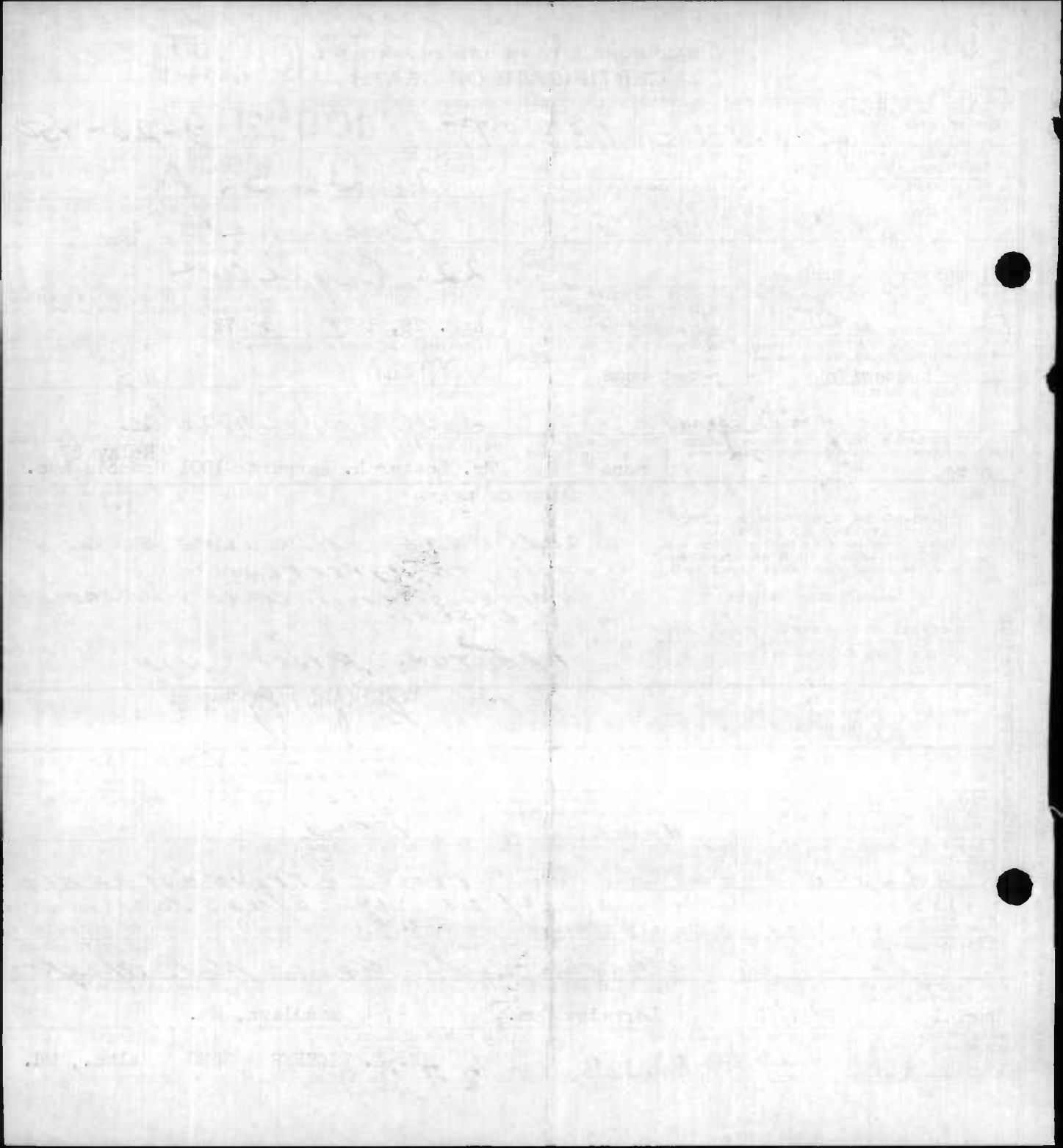
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N-8200

186a

MEDICAL CERTIFICATION







50 2728

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2728  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES F. CRUSEY

2. DATE  
OF  
DEATH

Mar. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION 1825 Walbrook Ave.Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)  
retired painter10B. KIND OF BUSINESS OR INDUSTRY  
Insurance Co.

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

Oct. 5, 1874

9. AGE (In years - last birthday)

75

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Kate -

17. INFORMANT

ADDRESS

Miss Gertrude Crusey - 1825 Walbrook Ave.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

5 months

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Cerebral Hemorrhage  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular disease  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 23, 1950, to March 23, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 11 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/25/50

Druid Ridge Cem.

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

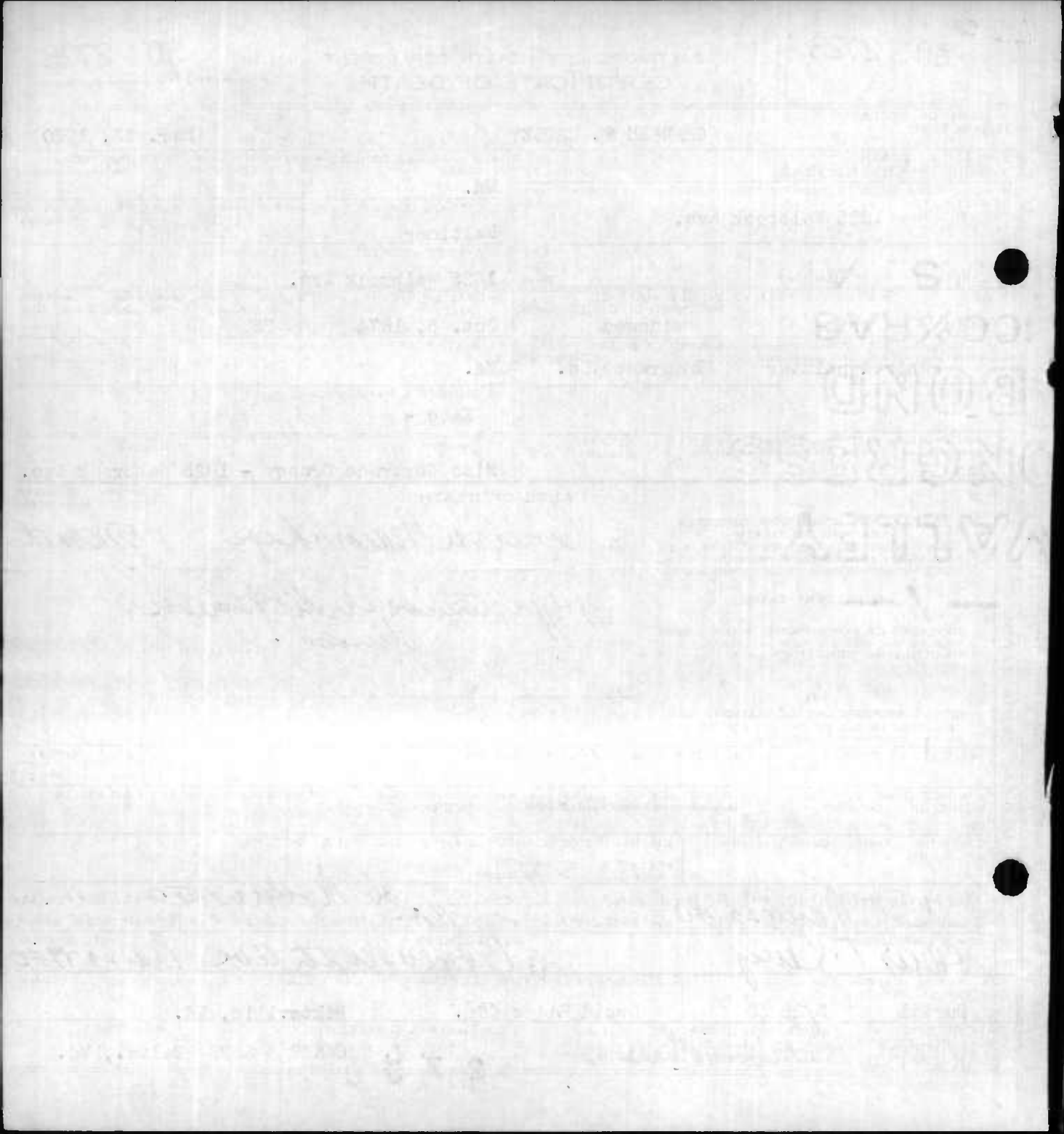
MAR 24 1950

Wm. J. Tickner &amp; Sons

Balto., Md.

Balto., Md.







correct age is especially important. Physicians: please write the causes of death clearly and legibly. The cause of death should be carefully supplied.

5050 2729

50 2729

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-05973

1. NAME OF DECEASED  
(Type or Print)

Charles

Evvin

Bacon

2. DATE  
OF  
DEATH

3/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Proident Hospital

Yrs.

Mos.

Days

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3/22/50

9. AGE (In years last birthday)

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Isaiah Bacon

14. MOTHER'S MAIDEN NAME

Audrey Marylin Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

mother

ADDRESS

1529 Jefferson St.

18. 762.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Pulmonary Atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/22/50, 1950, to 3/22, 1950, and that death occurred 9:25 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. D. Zwick

M. D.

23B. ADDRESS

Proident Hosp.

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL MAR 24 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. D. Zwick

25. FUNERAL DIRECTOR

27 Commissioner of Health

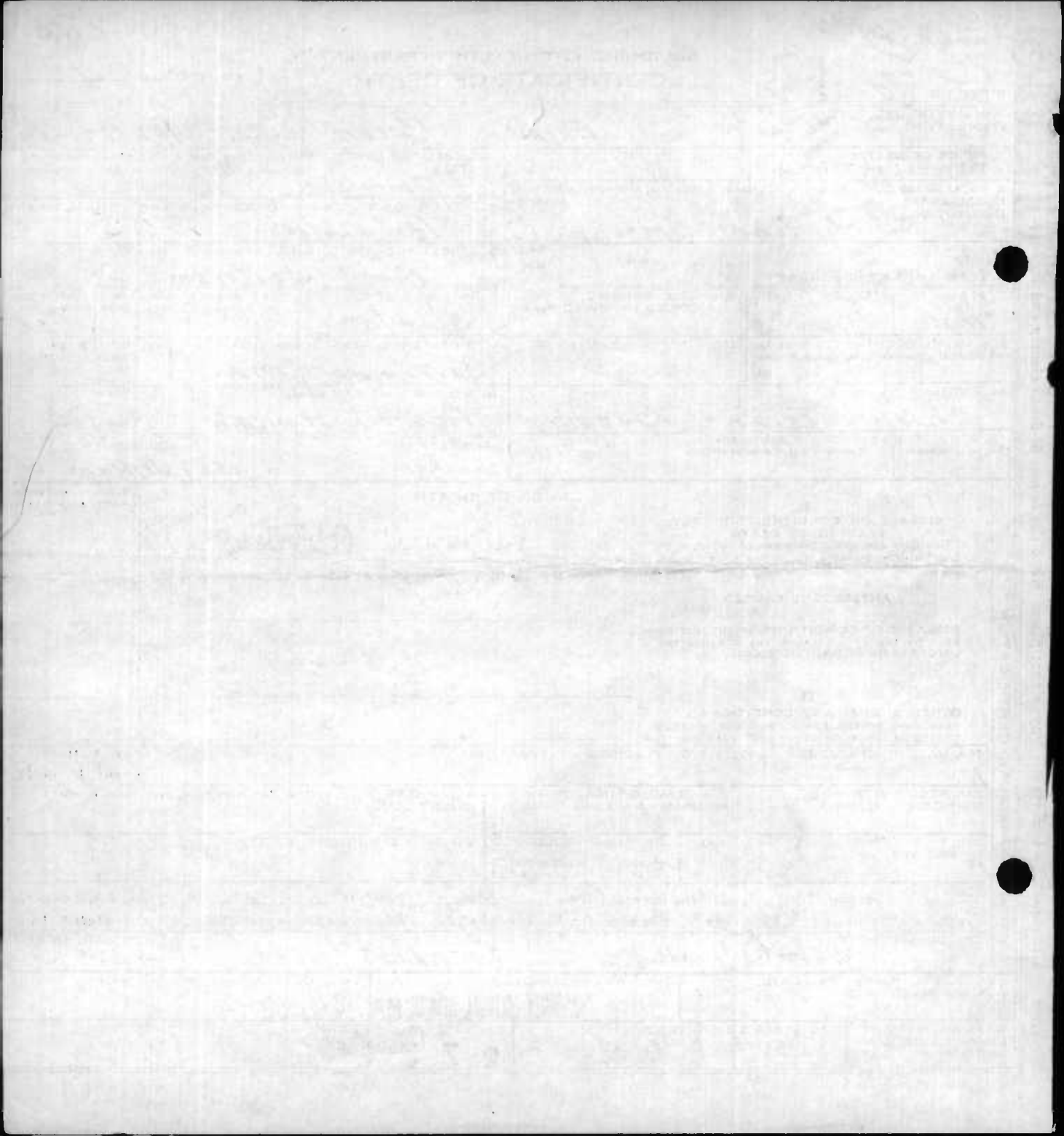
ADDRESS

MAR 24 1950

VS 150

161a











Body was in mercy Hosp. Morgan  
unknown to sister in charge

8770

3/27/50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

620  
50 2731

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2731  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Charles Myers Jr.</b>		2. DATE OF DEATH <b>MARCH 22, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pinecrest Sanatorium</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>1-02</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>513 S. Robinson St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1/18/1873</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>night watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	9. AGE (In years last birthday) <b>77</b>
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick Myers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles Myers Jr.</b>		ADDRESS <b>13 N. Lindwood Ave.</b>	

MEDICAL CERTIFICATION

18. <b>4721</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Myocarditis &amp; MYOCARDIAL DEGENERATION</b> DUE TO <b>ARTERIOSCLEROTIC</b> ANTECEDENT CAUSES <b>Generalized Arterio-sclerosis</b> DUE TO <b>Partial paralysis both legs</b>	CAUSE OF DEATH (A) <b>Chronic Myocarditis &amp; MYOCARDIAL DEGENERATION</b> (B) <b>Generalized Arterio-sclerosis</b> (C) <b>Partial paralysis both legs</b>	INTERVAL BETWEEN ONSET AND DEATH <b>? years</b> <b>? years</b> <b>5 YEARS</b>
---	--	--

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>JUNE 1</b> , 19 <b>48</b> , to <b>MARCH 22</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>MARCH 21</b> , 19 <b>50</b> , and that death occurred at <b>9:30 A</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <b>Melvin N. Borden</b>	23B. ADDRESS <b>2030 W. Fayette St.</b>	23C. DATE SIGNED <b>3/22/50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Mar. 25</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>North Ave. &amp; Rose St.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>	REGISTRAR'S SIGNATURE <b>William F. Hoffmann</b>	25. FUNERAL DIRECTOR <b>William F. Hoffmann</b>	ADDRESS <b>1639 N. Broadway</b>







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

530

50 2732

CERTIFICATE CORRECTED

3-27-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 2732  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Grace C. Smith

2. DATE  
OF  
DEATH

Mar 23-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

5415 Hillburn Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-04A

D. STREET ADDRESS (If rural, give location)

5415 Hillburn Ave

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

B. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year 11 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

331 X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 20, 1950, to March 23, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 10 A. m., from the causes and on the date stated above.

23A. SIGNATURE

L. J. Gordy

23B. ADDRESS

5106 Harford Road

23C. DATE SIGNED

3-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

Thurston Williams

5305 Harford Rd

VS 150

83a



Dr. J. J. Drapard



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-325 50 2733

Sedicum

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2733

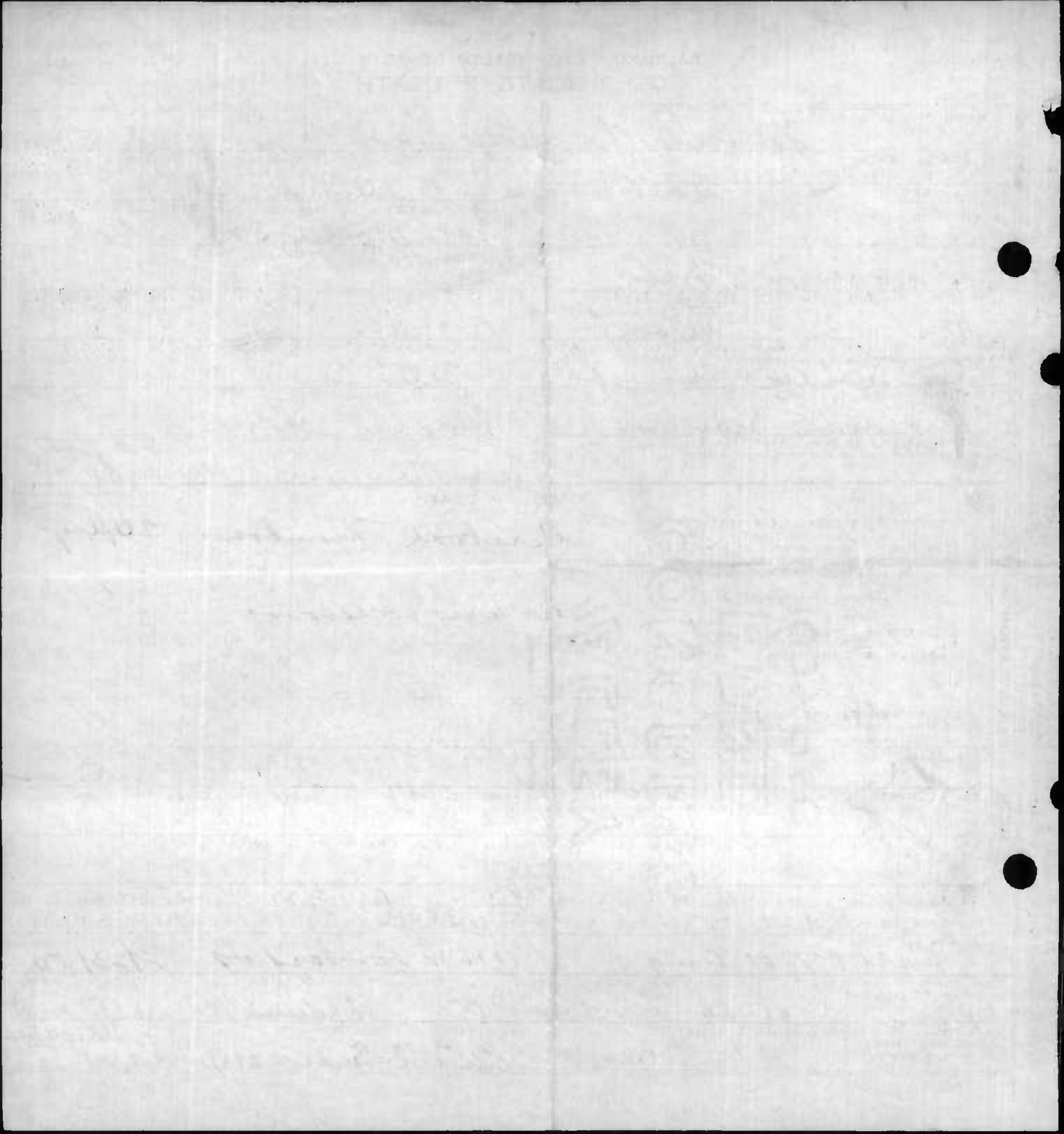
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Stanton Sedicum</i>			2. DATE OF DEATH <i>3/22/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1015 Morley St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>City</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>1015 Morley St 20-07</i>		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12-8-1864</i>	9. AGE (In years, last birthday) <i>85</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stone molder</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Stone mfg</i>		
11. BIRTHPLACE (State or foreign country) <i>Balto Co.</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Benjamin Sedicum</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca Wade</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Jamette Hoyer</i>			ADDRESS <i>Balto 1015 Morley St</i>		
18. <i>332X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) <i>Cerebral Thrombosis</i> <i>20 days</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) <i>Arteriosclerosis</i> <i>?</i>		
19A. DATE OF OPERATION <i>0</i>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>3/3</i> , 19 <i>50</i> , to <i>3/21</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/21</i> , 19 <i>50</i> , and that death occurred at <i>3:00 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Carol Hoyer</i>		23B. ADDRESS <i>1316 W Lombard St</i>		23C. DATE SIGNED <i>3/23/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-25-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Fondren Pk</i>	24D. LOCATION (City, town, or county) (State) <i>Fredrick Rd Balto Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 24 1950</i>		REGISTRAR'S SIGNATURE <i>William H. Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Edmund Paulson</i> ADDRESS <i>2359 Wood Blvd Balto Md</i>	

VS 150

83B







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2734

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jannie Jones

2. DATE  
OF  
DEATH

March 23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONLittle Sisters of the Poor  
Home for the Aged4. USUAL RESIDENCE (Where deceased lived. If institution, residence  
before admission)  
A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

1200 Valley St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

79

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas B. Jones

14. MOTHER'S MAIDEN NAME

Martha Keating

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT (Name and Address)

1200 Valley St.

18. 443X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Edema Lungs

1 day

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Hypertensive Cardio Vascular Disease

5 yrs

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐HOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Jan 15, 1950, to March 23, 1950, that I last saw the  
deceased alive on March 22, 1950, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

E. Gill Hall MD

M. D.

23B. ADDRESS

1631 E North Ave

23C. DATE SIGNED

March 29 - 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

March 27/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

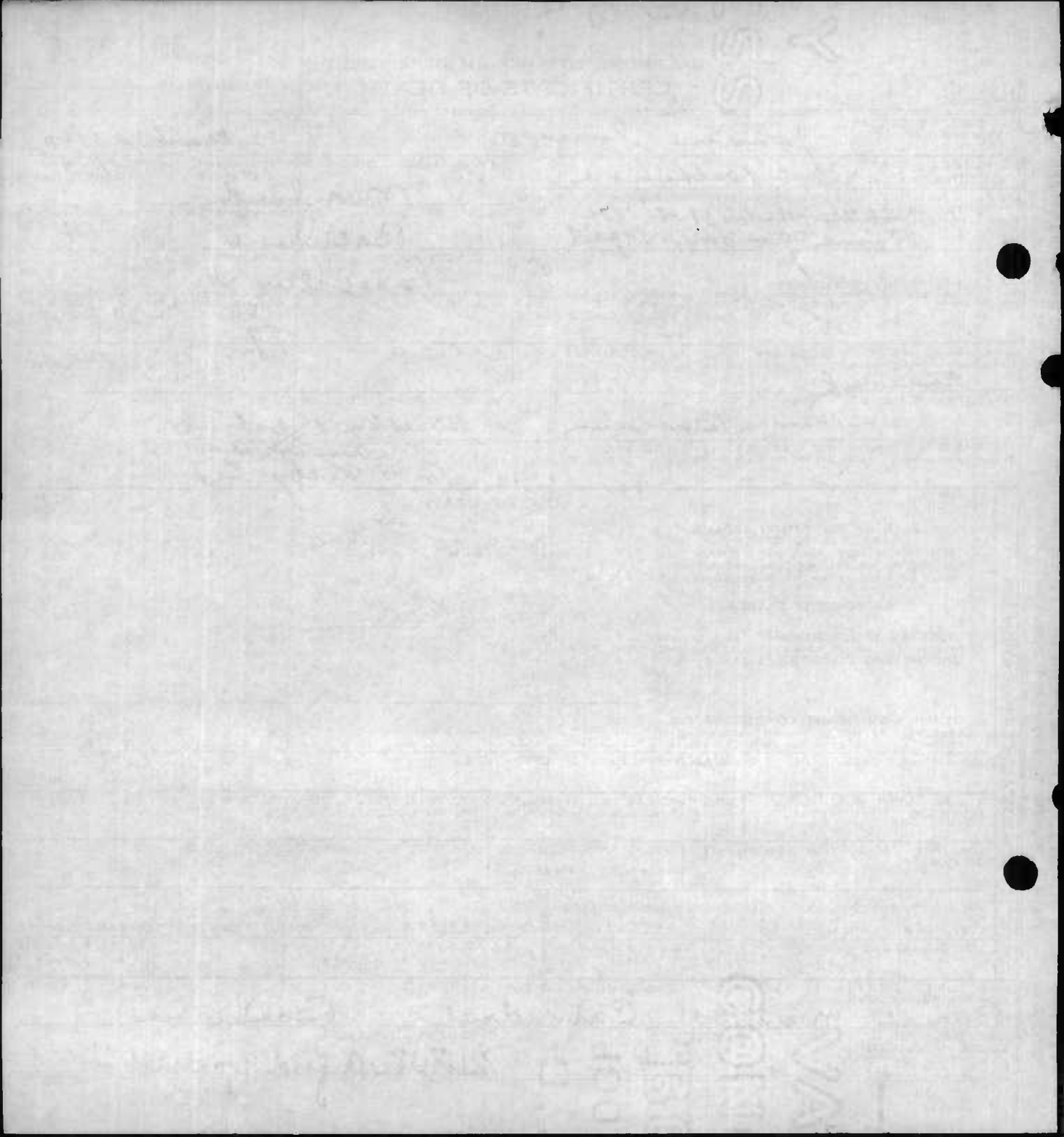
E. Gill Hall MD

25. FUNERAL DIRECTOR

ADDRESS

Blair Winfield 900 Biddle St







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620

GARRISH

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2735

Registered No. \_\_\_\_\_

BIRTH NO. 50 2735

1. NAME OF DECEASED (Type or Print) <i>William Garrish</i>			2. DATE OF DEATH <i>March 23, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor Home for the Aged</i>			C. CITY OR TOWN (If outside corporate limits, write U.S.A. and give township) <i>Baltimore</i>		
5. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>1200 Valley St</i>		
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>	8. DATE OF BIRTH <i>June 29, 1865</i>	9. AGE (In years last birthday) <i>84</i>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>			11. BIRTHPLACE (State or foreign country) _____		
10B. KIND OF BUSINESS OR INDUSTRY _____			12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME <i>Charles Garrish</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Amode</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <i>Little Sisters of the Poor</i> ADDRESS <i>1200 Valley St</i>			_____		

18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Bronchitis</i> DUE TO _____	INTERVAL BETWEEN ONSET AND DEATH <i>49 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Chronic Myocarditis</i> DUE TO _____	<i>5 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>March 20</i> , 1950, to <i>March 23</i> , 1950, that I last saw the deceased alive on <i>March 22</i> , 1950, and that death occurred at <i>12:00 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>E. Gell Hall M.D.</i>		23B. ADDRESS <i>1631 E North Ave</i>		23C. DATE SIGNED <i>March 24-1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		25. FUNERAL DIRECTOR ADDRESS <i>Bera Wildefeld 900 Biddle St</i>			

937



RECEIVED

RECEIVED  
FEB 10 1964  
U.S. DEPT. OF JUSTICE





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Henry C. Fowler, Jr.

2. DATE  
OF  
DEATH

March 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

Maryland

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

5200

D. STREET ADDRESS (If rural, give location)

321 Westowne Road

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 11, 1948

9. AGE (In years, last birthday)

11 Under 1 Year

11 Under 24 Hours

Months: Days

Hours: Min.

15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Henry C. Fowler, Sr.

14. MOTHER'S MAIDEN NAME

Mary V. Donnelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Henry C. Fowler, Sr.

321 Westowne Rd.

18. 193 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage @ 8 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Medulloblastoma Cerebelli

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

March 23, 1950

(Craniotomy)

Medulloblastoma Cerebelli

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK

NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from March 17, 1950, to March 23, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 7:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Dr. Smullen

M. D.

Sherry Hoop.

3/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/27/50

Morland Memorial

Baltimore

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

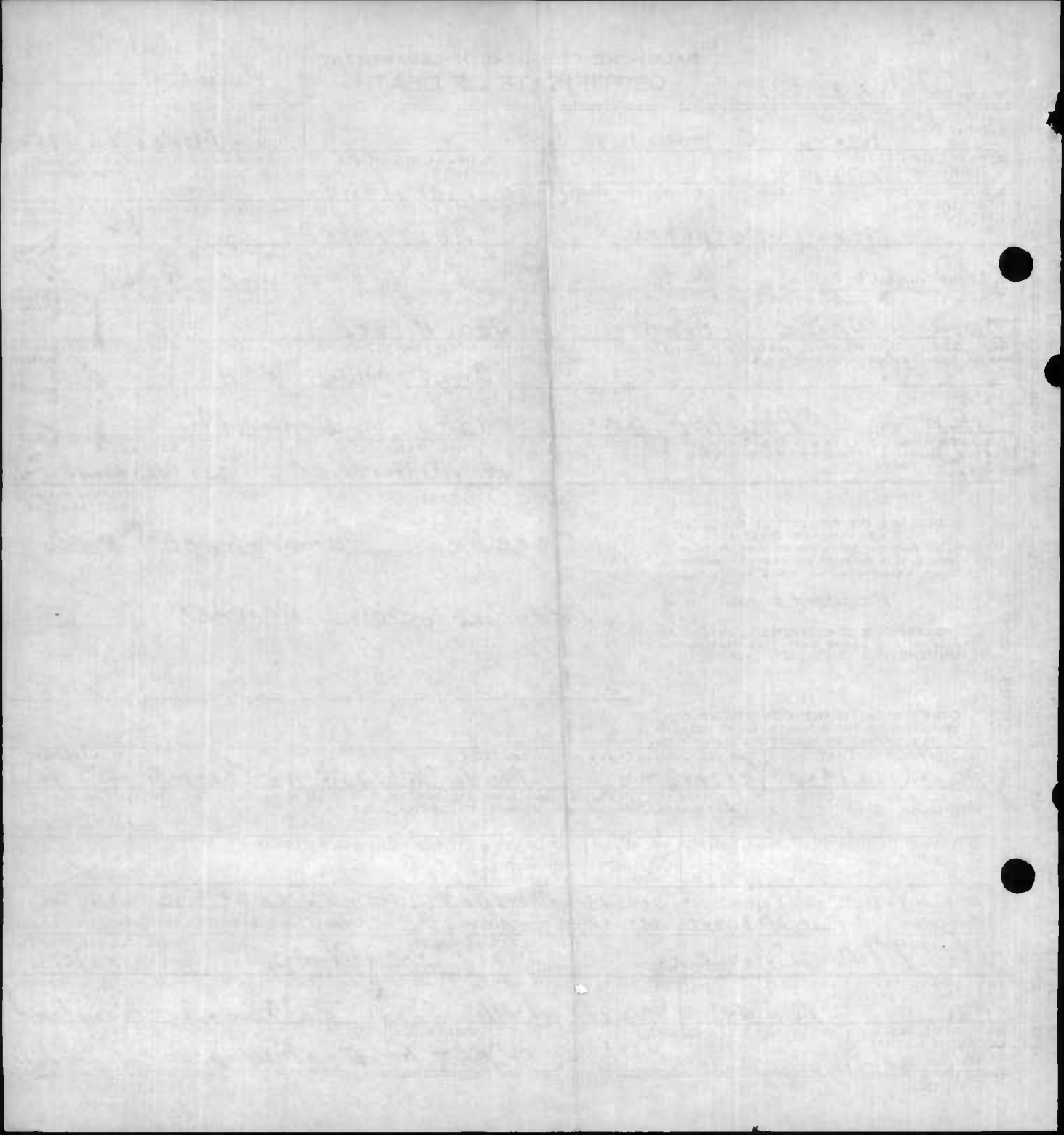
ADDRESS

MAR 24 1950

John F. Stansbury

2700 Edmondson Ave.







PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied, as it is extremely important. Physicians: please write the causes of death clearly and legibly.

552

JL-136498

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2737

Registered No.

BIRTH NO. 2737

1. NAME OF DECEASED (Type or Print) <b>Mabel Simmons</b>		2. DATE OF DEATH <b>3-12-50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <b>Md.</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. Length of stay in Baltimore <b>30 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>1525 W. Fayette St.-23</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>June 5, 1882</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>67</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>	
13. FATHER'S NAME <b>?</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave</b>		ADDRESS	

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Arteriosclerotic heart Disease</b> <b>and c failure auricular fibrillation and pulmonary edema</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cellulitis of leg.</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>March 11</b> , 19 <b>50</b> to <b>Mar. 12</b> , 19 <b>50</b> that I last saw the deceased alive on <b>Mar. 12</b> , 19 <b>50</b> and that death occurred at <b>7.50AM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>24th and 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Park</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR <b>Walt Bradley, Dundalk, Md</b>	

VS 150

937



April 24, 1954

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to you for your information and for your use in the event you are requested to comment on the subject.

Very truly,  
Yours,  
[Signature]

Enclosure

Very truly,  
Yours,  
[Signature]

Very truly,  
Yours,  
[Signature]

30

Very truly,  
Yours,  
[Signature]

Very truly,  
Yours,  
[Signature]

[Handwritten signature]



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

535  
50 2738

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2738  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THERESA E. FONTANA

2. DATE  
OF  
DEATH

3/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

ST. JOSEPH'S HOSP.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

MD.

B. COUNTY  
Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

OWINGS MILLS 5300

D. STREET ADDRESS (If rural, give location)

LYONS MILL ROAD

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Jan. 29 1896

9. AGE (In years;  
last birthday)

54

10. Under 1 Year

1

11. Under 24 Hours

22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Anthony Varella

14. MOTHER'S MAIDEN NAME

Rosa Poggi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

HOSPITAL RECORDS

18. 4/20/1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/7/50, 19, to 3/22/50, 19, that I last saw the deceased alive on 3/22/50, and that death occurred at 3:15 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Thaddeus Swinski

M. D.

23B. ADDRESS

St. Joseph's Hosp.

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 25 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

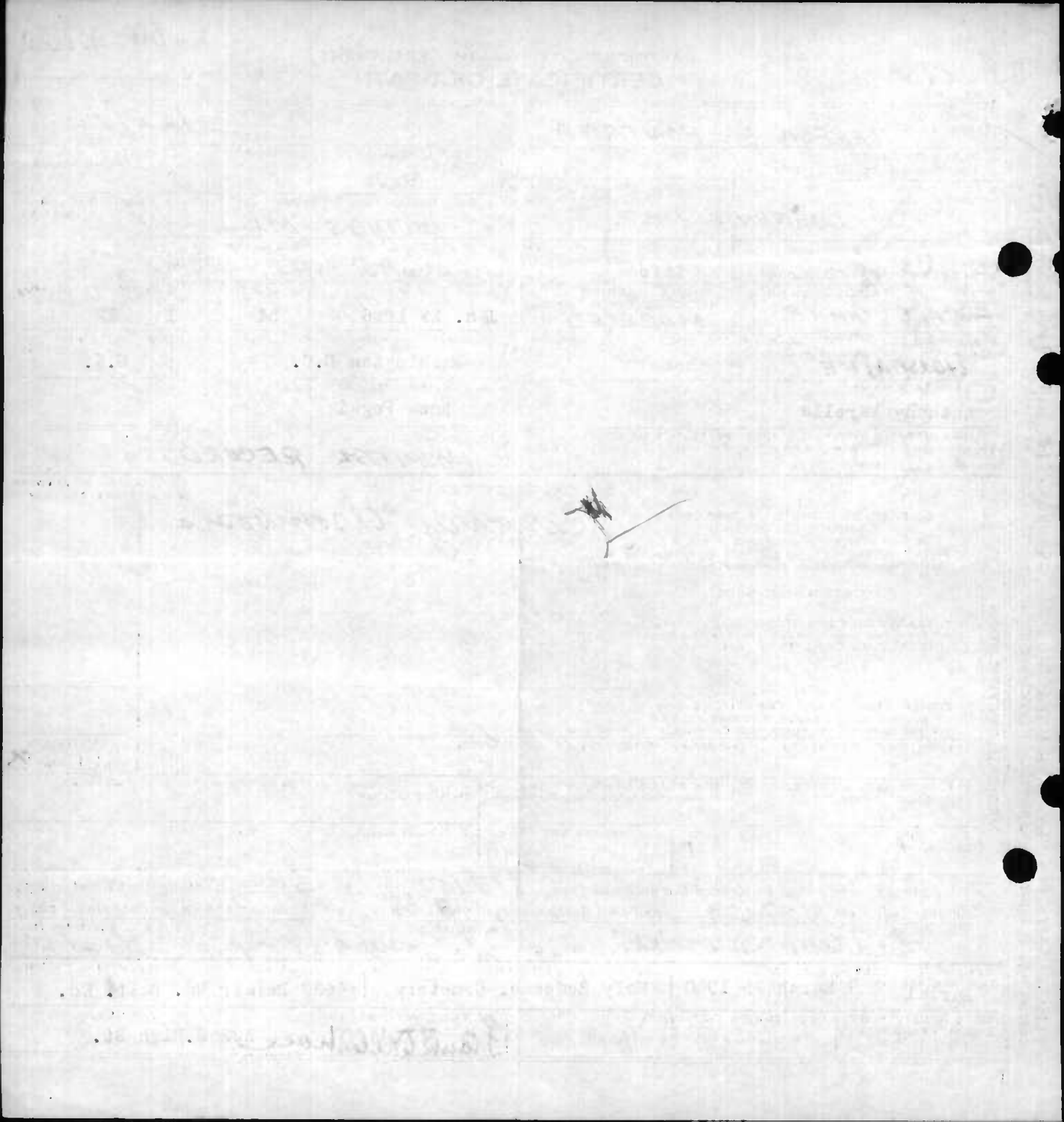
Thaddeus Swinski

25. FUNERAL DIRECTOR

ADDRESS

Frank W. H. H. 322 S. High St.







PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2739  
Registered No.

50 2739  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Miss Margaret Elizabeth Biddlingmayer</i>		2. DATE OF DEATH <i>3/24/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>General Human Aged Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 28-04</i>	
D. STREET ADDRESS (If rural, give location) <i>22 S. Atthal Ave</i>		E. LENGTH OF STAY IN BALTIMORE <i>Life</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Jan. 3, 1855</i>
9. AGE (In years last birthday) <i>95</i>		10. UNDER 1 YEAR Months: Days	
11. UNDER 24 HOURS Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>		13. FATHER'S NAME <i>John Biddlingmayer</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret Fitzgerald</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. J. Geo. Wolf</i>	
ADDRESS <i>22 S. Atthal Ave.</i>			

18. <i>491X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Broncho-Pneumonia</i> DUE TO		CAUSE OF DEATH <i>Broncho-Pneumonia</i> Mch. 22 to 24/50		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Multiple Sclerosis.</i> Gradual.		(B)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Mch. 22/50</i> , 19__, to <i>Mch. 24/50</i> , 19__, that I last saw the deceased alive on <i>Mch. 24/50</i> , and that death occurred at <i>6 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Harry H. ...</i>		23B. ADDRESS <i>933 Hanover Balto. Md</i>		23C. DATE SIGNED <i>Mch. 24/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/27/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) <i>4300 Old Fresh Pl. Balto.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>3/24/50</i>		24F. REGISTRAR'S SIGNATURE <i>Harry H. ...</i>	
24G. FUNERAL DIRECTOR <i>Harry H. ...</i>		24H. ADDRESS <i>4101 Edmondson</i>		24I. SIGNATURE <i>87D</i>	



OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

320

CERTIFICATE CORRECTED 4-10-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

2740

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **LILLIAN T. GATES**

2. DATE OF DEATH **March 23, 1950**

3. PLACE OF DEATH:  
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**University Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**2 S. Calhoun Street**

E. Length of stay in Baltimore

5. SEX

**female**

6. COLOR OR RACE

**white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Widow**

8. DATE OF BIRTH

**May 6, 1891**

9. AGE (In years last birthday)

**57**

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Sewing Machine operator**

10B. KIND OF BUSINESS OR INDUSTRY

**Blue Ridge Inc. CLOTHING Co.**

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Joseph Roche**

14. MOTHER'S MAIDEN NAME

**Louisa Zinkhan**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

**216-05-1580**

17. INFORMANT

**Mr. Ralph Gregory 3933 W. Mulberry St.**

ADDRESS

18. **E812.0**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

**multiple fractures**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Coronary Occlusion**

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
**street**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
**Baltimore and Pine Streets**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
**March 23, 1950 7.35 a.m.**

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?  
**Pedestrian struck by trailer-truck**

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Earl L. Royer**

23B. CHIEF MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAMINER  
M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED  
**March 23, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**3.27.50**

24C. NAME OF CEMETERY OR CREMATORY  
**Lorraine Park**

24D. LOCATION (City, town, or county) (State)  
**Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

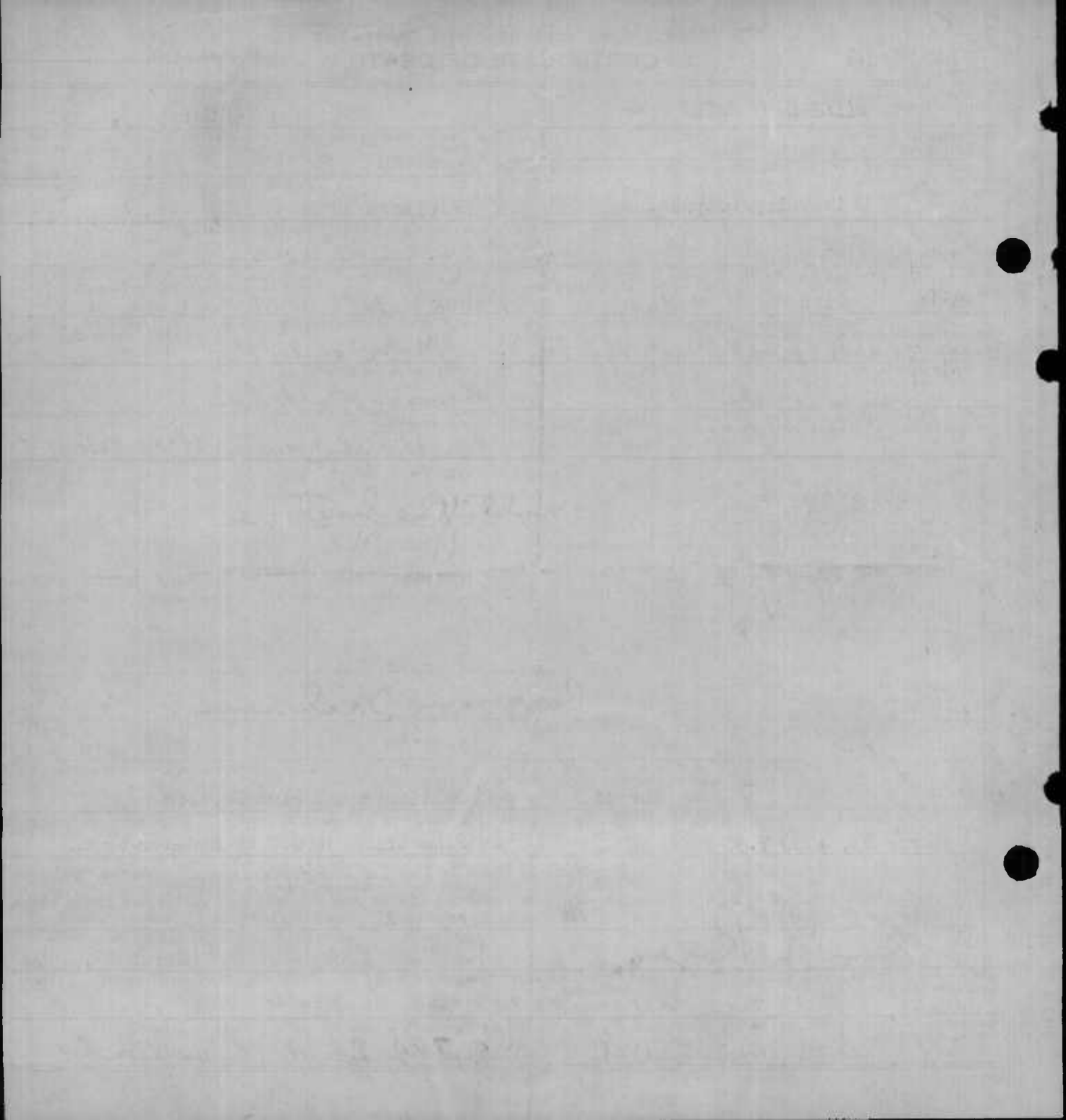
VS 151

**N-829.2**

**49606**

**170c**







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2741  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARIE LILLIAN CARTER

2. DATE  
OF  
DEATH

MARCH 22, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

757 W. SARATOGA St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

a. STATE MARYLAND

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

4-02

d. STREET ADDRESS (If rural, give location)

757 W. SARATOGA St.

c. Length of stay in Baltimore

23 yrs.

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG. 17, 1899

9. AGE (In years  
last birthday)

50

10. Under 1 Year  
Months: Days

7 5

11. Under 24 Hours  
Hours: Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

CHARLOTTE, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Augustus HARRIS

14. MOTHER'S MAIDEN NAME

JANIE WALLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

JAMES CARTER

ADDRESS

757 W. SARATOGA St.

18. 490X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

CORONARY OCCLUSION

INTERVAL BETWEEN  
ONSET AND DEATH

DAY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

LOBAR PNEUMONIA

Several wks.

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 3-13, 1950, to 3-22, 1950, that I last saw the  
deceased alive on 3-21, 1950, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE

Richard H. Hunt

M. D.

23b. ADDRESS

1631 W. Franklin St.

23c. DATE SIGNED

3-22-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

3-27-50

24c. NAME OF CEMETERY OR CREMATORY

MTCALVARY

24d. LOCATION (City, town, or county)

BALTIMORE

(State)

M.D.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

Huntington, Virginia, Va.

WM. A. JACKSON, 916 PENNA. AVE.



DECLARATION OF DEATH  
STATE OF NEW YORK

1. Name of Deceased		2. Date of Death	
3. Place of Death		4. Cause of Death	
5. Age of Deceased		6. Sex of Deceased	
7. Marital Status		8. Occupation	
9. Residence		10. Signature of Declarant	
11. Date of Declaration		12. Signature of Physician	
13. Signature of Coroner		14. Signature of Medical Examiner	
15. Signature of Registrar		16. Signature of Clerk	
17. Signature of Justice		18. Signature of Judge	
19. Signature of Mayor		20. Signature of Town Clerk	
21. Signature of Village Clerk		22. Signature of School Board	
23. Signature of Board of Health		24. Signature of Board of Education	
25. Signature of Board of Fire		26. Signature of Board of Police	
27. Signature of Board of Water		28. Signature of Board of Sewer	
29. Signature of Board of Gas		30. Signature of Board of Electric	
31. Signature of Board of Telephone		32. Signature of Board of Cable	
33. Signature of Board of Fire Insurance		34. Signature of Board of Life Insurance	
35. Signature of Board of Marine Insurance		36. Signature of Board of Fire Insurance	
37. Signature of Board of Life Insurance		38. Signature of Board of Marine Insurance	
39. Signature of Board of Fire Insurance		40. Signature of Board of Life Insurance	
41. Signature of Board of Marine Insurance		42. Signature of Board of Fire Insurance	
43. Signature of Board of Life Insurance		44. Signature of Board of Marine Insurance	
45. Signature of Board of Fire Insurance		46. Signature of Board of Life Insurance	
47. Signature of Board of Marine Insurance		48. Signature of Board of Fire Insurance	
49. Signature of Board of Life Insurance		50. Signature of Board of Marine Insurance	
51. Signature of Board of Fire Insurance		52. Signature of Board of Life Insurance	
53. Signature of Board of Marine Insurance		54. Signature of Board of Fire Insurance	
55. Signature of Board of Life Insurance		56. Signature of Board of Marine Insurance	
57. Signature of Board of Fire Insurance		58. Signature of Board of Life Insurance	
59. Signature of Board of Marine Insurance		60. Signature of Board of Fire Insurance	
61. Signature of Board of Life Insurance		62. Signature of Board of Marine Insurance	
63. Signature of Board of Fire Insurance		64. Signature of Board of Life Insurance	
65. Signature of Board of Marine Insurance		66. Signature of Board of Fire Insurance	
67. Signature of Board of Life Insurance		68. Signature of Board of Marine Insurance	
69. Signature of Board of Fire Insurance		70. Signature of Board of Life Insurance	
71. Signature of Board of Marine Insurance		72. Signature of Board of Fire Insurance	
73. Signature of Board of Life Insurance		74. Signature of Board of Marine Insurance	
75. Signature of Board of Fire Insurance		76. Signature of Board of Life Insurance	
77. Signature of Board of Marine Insurance		78. Signature of Board of Fire Insurance	
79. Signature of Board of Life Insurance		80. Signature of Board of Marine Insurance	
81. Signature of Board of Fire Insurance		82. Signature of Board of Life Insurance	
83. Signature of Board of Marine Insurance		84. Signature of Board of Fire Insurance	
85. Signature of Board of Life Insurance		86. Signature of Board of Marine Insurance	
87. Signature of Board of Fire Insurance		88. Signature of Board of Life Insurance	
89. Signature of Board of Marine Insurance		90. Signature of Board of Fire Insurance	
91. Signature of Board of Life Insurance		92. Signature of Board of Marine Insurance	
93. Signature of Board of Fire Insurance		94. Signature of Board of Life Insurance	
95. Signature of Board of Marine Insurance		96. Signature of Board of Fire Insurance	
97. Signature of Board of Life Insurance		98. Signature of Board of Marine Insurance	
99. Signature of Board of Fire Insurance		100. Signature of Board of Life Insurance	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2742

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*William F. Schlunderberg*

2. DATE OF DEATH

*3/24/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

*Church Home + Hospital*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

*Balto.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*3613 Lochearn Drive*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Butcher (Owner)*

10B. KIND OF BUSINESS OR INDUSTRY

*Butchering*

11. BIRTHPLACE (State or foreign country)

*MD.*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*George Schlunderberg*

14. MOTHER'S MAIDEN NAME

*Elizabeth Franks*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*George Schlunderberg*

*same*

18. *450.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) *Pruritus*

DUE TO

*4 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Generalized arteriosclerosis*

DUE TO

*8 years*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3/7*, 19*50* to *3/24*, 19*50*; that I last saw the deceased alive on *3/24*, 19*50*, and that death occurred at *7:50 PM*, from the causes and on the date stated above.

23A. SIGNATURE

*James G. Means*

23B. ADDRESS

*Church Home + Hospital*

23C. DATE SIGNED

*3/24/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/27/50*

24C. NAME OF CEMETERY OR CREMATORY

*Lorraine Cem.*

24D. LOCATION (City, town, or county) (State)

*Woodlawn, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston W. Williams*

25. FUNERAL DIRECTOR

*J. M. J. TUCKER & SONS*

ADDRESS

*Balto., Md.*



1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2743  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Elsie Jones</i>			2. DATE OF DEATH <i>Nov. 22, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. City</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 17-01</i>		
c. Length of stay in Baltimore <i>9 Yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>162020 Argyle Ave</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>9-1-20</i>	9. AGE (In years last birthday) <i>29</i>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Fruitland Maryland</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Walter Turpin</i>			14. MOTHER'S MAIDEN NAME <i>Louise Stevenson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>			ADDRESS		

MEDICAL CERTIFICATION

18. <i>171X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Epidermoid Carcinoma of Breast</i> DUE TO (A) _____ ANTECEDENT CAUSES (B) <i>none.</i> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) <i>none.</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <i>Epidermoid Carcinoma of Breast</i> <i>18 months</i>	INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i>
--	---	--

19A. DATE OF OPERATION <i>2-9-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Epidermoid Ca. Extended to Ovaries and Uterus.</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>1/17</i> , 19 <i>50</i> , to <i>3/22</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/22</i> , 19 <i>50</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Robert P. Ordumell, M.D.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>
23C. DATE SIGNED <i>3-22-50</i>		

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/25/1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Eastern Shore Md</i>	24D. LOCATION (City, town, or county) (State) <i>Eastern Shore Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 24 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>Elroy J. Wilson</i>	ADDRESS <i>4000 Brantly Ave</i>



Laosnia  
Cern



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2744  
Registered No. \_\_\_\_\_

50 2744  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Joseph Lester Weihrauch

2. DATE OF DEATH

Mar. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1804 N. Washington St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

00

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

8-05

D. STREET ADDRESS (If rural, give location)

1804 N. Washington St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 19, 1902

9. AGE (In years last birthday)

47

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Insulation Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Superior Ins. Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph J. Weihrauch

14. MOTHER'S MAIDEN NAME

May King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and dates of service)

no

16. SOCIAL SECURITY NO.

213-03-1495

17. INFORMANT

Mrs. J. J. Weihrauch - 1804 N. Washington St.

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 22, 1950, to March 23, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 9 A m., from the causes and on the date stated above.

23A. SIGNATURE

Kurt Fisher

23B. ADDRESS

1823 N. Wash. St.

23C. DATE SIGNED

3/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 24 1950

REGISTRAR'S SIGNATURE

Thurston Whitcomb

25. FUNERAL DIRECTOR

E. J. Flannery & Son - 1938 E. Lafayette Ave.

ADDRESS



DEPARTMENT OF HEALTH

STATE OF NEW YORK

3



The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 2745  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2745  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Dorothy Justice</i>		2. DATE OF DEATH <i>3/23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>12-03</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>5422 Guilford Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Sept, 1911</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <i>38</i>
11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Hay</i>		14. MOTHER'S MAIDEN NAME <i>Mary Stewart</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <i>223 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Meningoencephalitis</i> DUE TO (B) <i>Meningioma</i> DUE TO (C) <i>Pneumonia</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5mo.</i> <i>?</i> <i>3-weeks</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>10-11-48</i>		19B. MAJOR FINDINGS OF OPERATION <i>Meningioma</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-4</i> , 19 <i>49</i> , to <i>3-23</i> , 19 <i>50</i> that I last saw the deceased alive on <i>3-23</i> , 19 <i>50</i> , and that death occurred at <i>6 P. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS M. D. <i>Maryland General Hospital</i>		23C. DATE SIGNED <i>3/23/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		24B. DATE <i>3/24/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Union</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25. FUNERAL DIRECTOR'S ADDRESS <i>1217 H. Condit St</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 24 1950</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		567	



CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY NUMBER

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

620

50 2746

U.R.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2746

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sharon L. Cross		2. DATE OF DEATH March 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 815 N. Rose Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-02	
c. Length of stay in Baltimore 2 mos		D. STREET ADDRESS (If rural, give location) 815 N. Rose Street	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Jan 22, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 2 3
11. BIRTHPLACE (State or foreign country) Maryland, Anne Arundle Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Roland Cross		14. MOTHER'S MAIDEN NAME Rita Kuzma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rita & Roland Cross, 815 N. Rose Street		ADDRESS	

18. 744.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Amyotonia Congenita. DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 mos.	19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)
--	---

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 24, 1950, to March 24, 1950, that I last saw the deceased alive on March 24, 1950, and that death occurred at 8:45 A. M., from the causes and on the date stated above.					
23A. SIGNATURE Albert C. Harrmann		23B. ADDRESS M. D. 2921 E. Federal St.		23C. DATE SIGNED March 24, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/50		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) Belair Road, Balto, Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR MAR 24 1950		24F. REGISTRAR'S SIGNATURE Huntington	
24G. DATE RECEIVED BY LOCAL REGISTRAR MAR 24 1950		24H. REGISTRAR'S SIGNATURE Huntington		24I. FUNERAL DIRECTOR Schmunek Funeral Home 2601-3-5 E. Madison St	

157 M







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

David James Bailey

2. DATE  
OF  
DEATH

May-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1432-E-Orlean St

C. Length of stay in Baltimore

2-Mos

SEX

Male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

general

13. FATHER'S NAME

James Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mamie J. Williams - Phila-Pa

18. 022X

CAUSE OF DEATH

acute

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RUPTURED aneurysm of abdominal  
DUE TO

3 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bessie Lues.  
DUE TO

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-20, 1950, to 3-22, 1950, that I last saw the deceased alive on 3-21, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

A. C. Burwell

23B. ADDRESS

1811 Airport

23C. DATE SIGNED

3-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 24 1950

William Williams

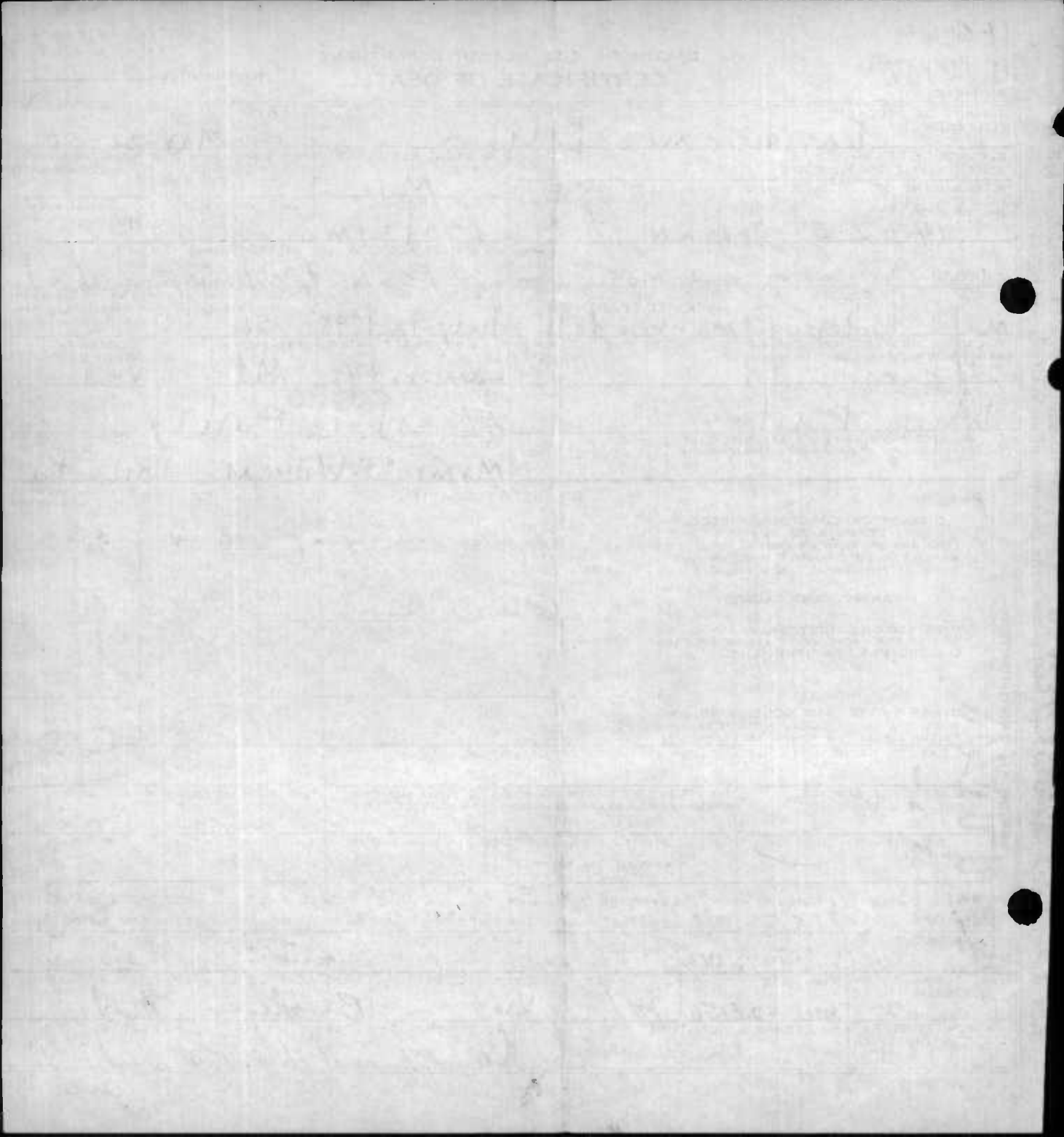
Holland Funeral Home, 1631 Grand Hill

VS 150

98899

301 are







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N-656

50 2748

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2748

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARGARET ELIZABETH WARNER

2. DATE  
OF  
DEATH

Mar. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2331 Harford Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2331 Harford Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Aug. 8, 1869

9. AGE (in years;  
last birthday)

80

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

never worked

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Warner

14. MOTHER'S MAIDEN NAME

Elizabeth Ament

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Wesley W. Gore

715 Murdock Rd.

18. 4/20-1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

1 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardio-vascular  
renal disease

5 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from Sept. 1949, to Mar. 23, 1950, that I last saw the deceased alive on Mar. 23, 1950, and that death occurred at 10:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Lloyd E. Saylor

M. D.

23B. ADDRESS

3902 Sheenmount av.

23C. DATE SIGNED

Mar. 24, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS

Balto., Md.



CERTIFICATE OF DEATH

REPORT BY THE DEATH REGISTRAR

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

AGE AT DEATH

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

AGE AT DEATH

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2749  
Registered No. \_\_\_\_\_

524  
50 2749  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Laura May Conklin</u>			2. DATE OF DEATH <u>3/23/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore, Md.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <u>The Union Memorial Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>12-02</u>		
c. Length of stay in Baltimore <u>Life</u>			D. STREET ADDRESS (If rural, give location) <u>233 E. University Parkway</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 14 1864</u>	9. AGE (In years last birthday) <u>65 yrs.</u>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Milton Miller</u>			14. MOTHER'S MAIDEN NAME <u>Lavinia Supplee</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <u>Mrs. E. Edgar Thompson (Daughter) Ruston 4 Maryland</u>		

MEDICAL CERTIFICATION	18. <u>420.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Multiple pulmonary emboli</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Generalized arteriosclerosis</u> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Old myocardial infarcts</u> <u>Arteriosclerotic heart disease - marked</u>				CAUSE OF DEATH <u>?</u> INTERVAL BETWEEN ONSET AND DEATH _____	
	19A. DATE OF OPERATION <u>2</u>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
	22. I hereby certify that I attended the deceased from <u>3/19</u> , 19 <u>50</u> , to <u>3/23</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3/23</u> , 19 <u>50</u> , and that death occurred at <u>9:30 A.</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>J. Frank Supplee, III</u>		23B. ADDRESS <u>Union Memorial Hosp.</u>		23C. DATE SIGNED <u>3/23/50</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-25-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemy.</u>		
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>		25. FUNERAL DIRECTOR <u>John O. Ritchell</u>				
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 24 1950</u>		REGISTRAR'S SIGNATURE <u>Wm. C. Ritchell</u>				

VS 150

26699

93D







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2750

1. NAME OF DECEASED  
(Type or Print) Mr Cyrus T. MASSIE

2. DATE OF DEATH 3/24/50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk - Balto (22)

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location) 7813 Meath Road. 5300

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 18 Oct 1905

9. AGE (In years last birthday) 44

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator

10B. KIND OF BUSINESS OR INDUSTRY CONST.

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW II

16. SOCIAL SECURITY NO.

17. INFORMANT Wife

ADDRESS Same

18. 5810

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro-intestinal hemorrhage

15 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Esophageal VARICES

years ??

(C) Cirrhosis of liver

yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 3/24/50

19B. MAJOR FINDINGS OF OPERATION Cirrhosis of liver

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 Mar, 1950, to 24 Mar, 1950 that I last saw the deceased alive on 24 Mar, 1950, and that death occurred at 7:50 Am., from the causes and on the date stated above.

23A. SIGNATURE Wayne M. Jacobus M.D. M.O.

23B. ADDRESS Church Home & Hosp.

23C. DATE SIGNED 24 Mar 50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 3-26-50

24C. NAME OF CEMETERY OR CREMATORY Lynchburg

24D. LOCATION (City, town, or county) Va. 2

DATE RECEIVED BY LOCAL REGISTRAR MAR 24 1950

REGISTRAR'S SIGNATURE Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS John & Mitchell & Sons inc.



DECLARATION OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

I, \_\_\_\_\_

do hereby certify that \_\_\_\_\_

has died at \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_

at the age of \_\_\_\_\_ years

and that the death was caused by \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

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and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

300

50 2751

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2751  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Simon Beattie

2. DATE  
OF  
DEATH

3/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Church Home & Hosp.

C. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

SLATE INDUSTRY

13. FATHER'S NAME

Mr. John Beattie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Kenneth Beattie Same

18. 331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

10 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Pulmonary Edema

36 hrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Gr. Atherosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/23, 1950, to 3/24, 1950, that I last saw the deceased alive on 3/24, 1950, and that death occurred at 3 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Emory

23B. ADDRESS

Church Home & Hosp.

23C. DATE SIGNED

3/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

APR 24 1950

25. FUNERAL DIRECTOR

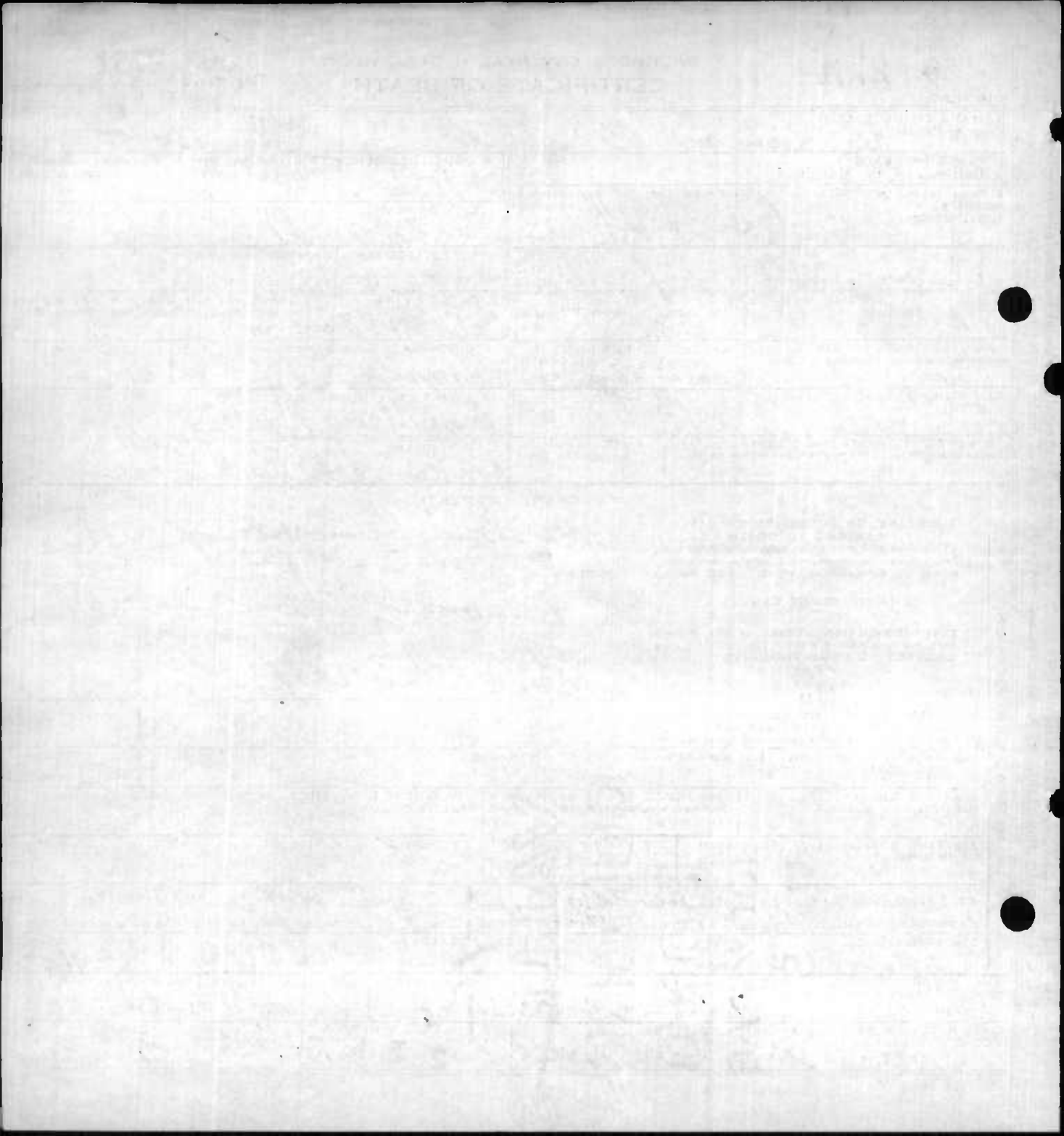
ADDRESS

VS 150

98124

830







540

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2752

Registered No.

50 2752  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

MARY ANN HENNEHLY

2. DATE  
OF  
DEATH

MAR. 21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore City 20-05

D. STREET ADDRESS (If rural, give location)

2686 St. Benedict - St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

House work

At Home

Balto. Co. Md.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Richard Hennehy

Margaret Schammell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

No

Margaret Chapin - 2557 Wilkes Ave

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from March 1 - 1950, to March 21, 1950, that I last saw the  
deceased alive on March 21, 1950, and that death occurred at 10:15 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Walter C. Hitch

M. D.

2151 Wilkes Ave

3/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 25 1950

Wilmington, Delaware

F. B. Lippert, Son - 1300 Eutaw Rd.

VS 150

93D 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

No. *100-100000-100000*

State of *California*

County of *San Diego*

City of *San Diego*

I, *John Doe*

do hereby certify that

*John Doe*

was born on *January 1, 1900*

at *San Diego, California*

and died on *January 1, 1900*

at *San Diego, California*

of the cause of death *Heart Disease*

at the age of *0* years

and was buried on *January 1, 1900*

at *San Diego, California*

in the presence of *John Doe*

and *John Doe*

and *John Doe*

and *John Doe*

and *John Doe*

and *John Doe*

and *John Doe*



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

400  
50 2753  
BIRTH NO.

Sheeley  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2753  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Catherine Sheeley</i>			2. DATE OF DEATH <i>March 23, 1960</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto.</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Home for the Aged</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Pikesville</i> 5300		
5. Length of stay in Baltimore SEX <i>F</i> 6. COLOR OR RACE <i>W.</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>			8. DATE OF BIRTH <i>Aug. 5, 1868</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>			9. AGE (In years last birthday) <i>81</i>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
13. FATHER'S NAME <i>Patrick Sheeley</i>			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>			14. MOTHER'S MAIDEN NAME <i>Bridget Reilly</i>		
16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Edna J. Smith</i> ADDRESS <i>1200 Valley St.</i>		

18. <i>422.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <i>Cerebral Arteriosclerosis</i> 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO <i>Chronic Myocarditis</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>5 yr</i>
---	--

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 10*, 1950, to *Mar 23*, 1950, that I last saw the deceased alive on *Mar 22*, 1950, and that death occurred at *8:45 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE *Ed Gell Hall M.D.* 23B. ADDRESS *1631 E North Ave* 23C. DATE SIGNED *Mar 24 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *3/27/50* 24C. NAME OF CEMETERY OR CREMATORY *St. Charles* 24D. LOCATION (City, town, or county) *Pikesville, Maryland*

DATE RECEIVED BY LOCAL REGISTRAR *Mar 25 1950* REGISTRAR'S SIGNATURE *Huntington Harrison* 25. FUNERAL DIRECTOR *Edna J. Smith* ADDRESS *937 Pikesville*



WALLER  
COMPRESS

BRAND

100% LVC

YIF

CERTIFICATE OF ANALYSIS  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

616

CERTIFICATE CORRECTED 4-10-50

50 2754

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2754  
Registered No.

1. NAME OF DECEASED (Type or Print) SAMUEL JOHN HARPER		2. DATE OF DEATH 3/24/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 12-06	
c. Length of stay in Baltimore 40 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2130 NO. EDWARD ST.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 1883 9/25/1883
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHANCEUR		10B. KIND OF BUSINESS OR INDUSTRY SCHOOL BUS	9. AGE (In years last birthday) 66 5-5-66
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME JOHN HARPER		14. MOTHER'S MAIDEN NAME ✓	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT LEWIS HARPER GARRISON		ADDRESS MD.	

MEDICAL CERTIFICATION	18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CORONARY OCCLUSION DUE TO (B) Cardiac insufficiency DUE TO (C) anturp salinis		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 yrs. 10 yrs.
	19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
	22. I hereby certify that I attended the deceased from 1940, 19, to June 22nd, 1950, that I last saw the deceased alive on March 22, 1950, and that death occurred at 2:30 P.m., from the causes and on the date stated above.		
23A. SIGNATURE George E. Green		23B. ADDRESS 28 W 215th St Balt. 18 Md	23C. DATE SIGNED 3-24-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/27/50	24C. NAME OF CEMETERY OR CREMATORY Parkwood	24D. LOCATION (City, town, or county) (State) Parkville Md.
DATE RECEIVED BY LOCAL REGISTRAR MAR 25 1950		REGISTRAR'S SIGNATURE Wilmington Williams, Md	25. FUNERAL DIRECTOR 4221 Cook Inc. 1217 St. Paul St.



DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of death: \_\_\_\_\_

5. Place of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Signature of physician: \_\_\_\_\_

8. Signature of registrar: \_\_\_\_\_

9. Date of registration: \_\_\_\_\_



Correct age is especially important. Physicians: please write the causes of death clearly and fully. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2755  
Registered No. 50 2755

650  
50 2755  
BIRTH NO. 50-01495

1. NAME OF DECEASED (Type or Print) <b>LEOLA GREEN</b>		2. DATE OF DEATH <b>March 23, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 23-01</b>	
D. STREET ADDRESS (If rural, give location) <b>46 W. West Street</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Child</b>	8. DATE OF BIRTH <b>1/20/50</b>
9. AGE (In years last birthday) <b>2</b>		10. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Russell Green</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Camphor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mabel Green-46 W. West Street</b>		ADDRESS <b>46 W. West Street</b>	

MEDICAL CERTIFICATION

18. <b>491X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> (A) DUE TO ANTECEDENT CAUSES (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. DATE OF OPERATION	19a. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21a. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

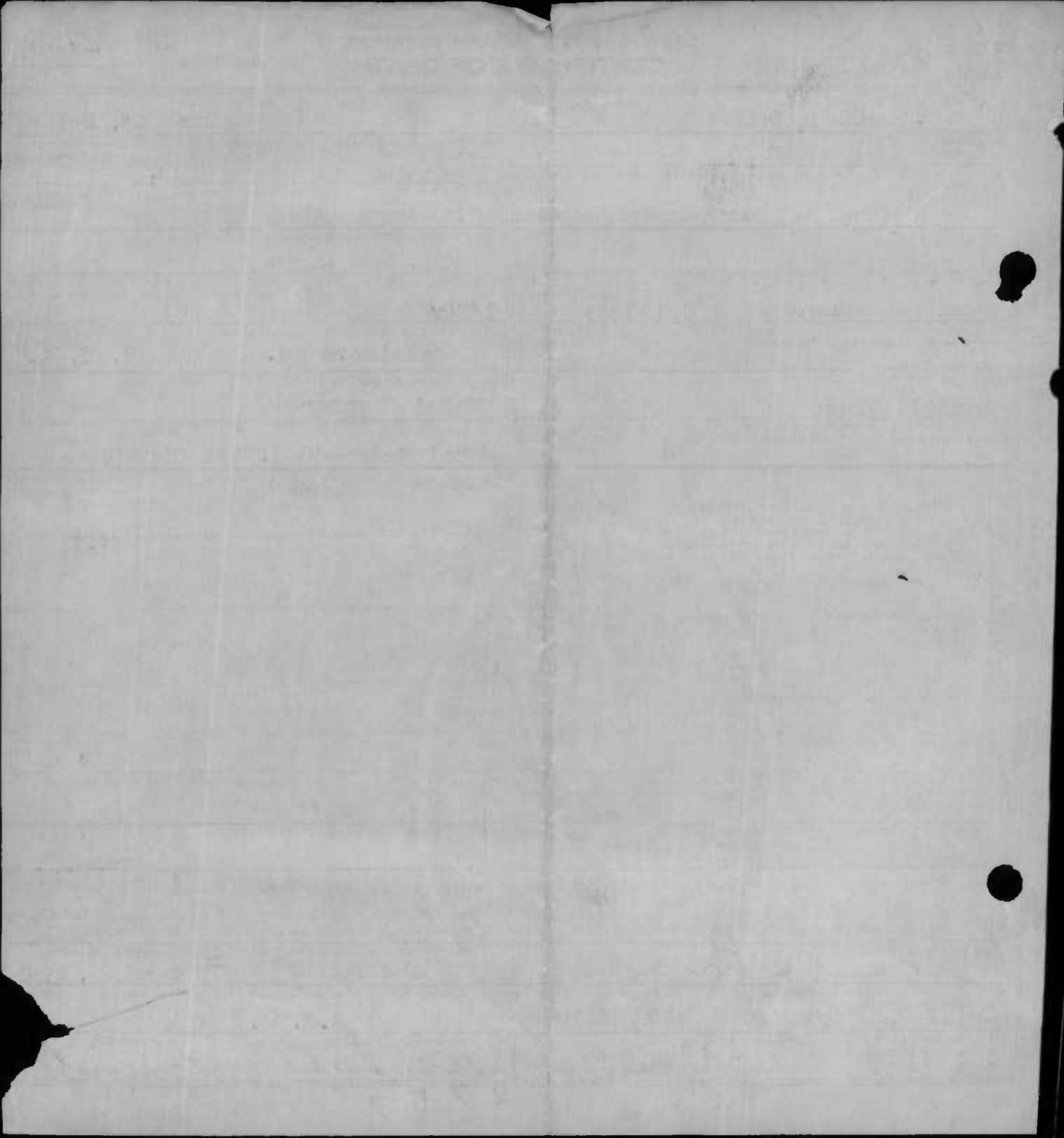
23A. SIGNATURE **Earl L. Royce**  
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☒ M.D. MEDICAL INVESTIGATOR ☐  
23C. DATE SIGNED **March 23, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**  
24B. DATE **3/25/50**  
24C. NAME OF CEMETERY OR CREMATORY **Mt. Calvary**  
24D. LOCATION (City, town, or county) (State) **A. A. Co., Md**

DATE RECEIVED BY LOCAL REGISTRAR **MAR 25 1950**  
REGISTRAR'S SIGNATURE **Wm. H. Williams, M.D.**  
25. FUNERAL DIRECTOR **J. L. Brown & Son - Montgomery St**  
ADDRESS **108 W**

VS 151  
2757  
107







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N-416

50 2756

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2756

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Paul V. Wolfrey

2. DATE  
OF  
DEATH

March 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Med. Ost. 6

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

Montgomery

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Spessersville

6500

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

10-9-35

9. AGE (In years  
last birthday)

14

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

High School

11. BIRTHPLACE (State or foreign country)

Parker Va

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wm Wolfrey

14. MOTHER'S MAIDEN NAME

Minerva Munnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 7544

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Congenital Heart Disease

14 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

(Truncus Arteriosus)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from 3-14-1950 to 3-24-1950, that I last saw the  
deceased alive on 3-24-1950 and that death occurred at 3:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert C. Hartmann

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

3/27/50

24D. LOCATION (City, town, or county) (State)

Union

24E. FUNERAL DIRECTOR

Burtonville Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

Donaldson, Laurel, Md

ADDRESS

MAR 25 1950

VS 150

157E



CERTIFICATE OF DEATH

1. Name of Deceased (Print Name)  
2. Date of Death  
3. Place of Death  
4. Cause of Death  
5. Signature of Physician  
6. Signature of Registrar  
7. Date of Registration



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 2757

50 2757

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CONSTANCE LOUISE COLES

2. DATE  
OF  
DEATH

Mar. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1146 N. Longwood St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

never worked

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

James Coles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

8. DATE OF BIRTH

Sept. 13, 1871

9. AGE (In years  
last birthday)

78

If Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Emma Harding

17. INFORMANT

ADDRESS

Miss Emma A. Ball - 1146 N. Longwood St.

18. 190x

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

5 yrs

3 yrs

3 mos

10 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/19, 1950, to 3/23, 1950, that I last saw the deceased alive on 3/23, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1202 St Paul St

8/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 25 1950

REGISTRAR'S SIGNATURE

Wm J. Stinson

25. FUNERAL DIRECTOR

ADDRESS

Wm J. Stinson & Sons

Balto., Md.



U. S. - A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-255

50 2758

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2758

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Alfred H. Rossman, Sr.*

2. DATE  
OF  
DEATH

*3/24/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*Mercy Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

*Maryland*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto.*

*26-04A*

D. STREET ADDRESS (If rural, give location)

*1011 Quantril Way*

C. Length of stay in Baltimore *Life*

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*July 29, 1886*

9. AGE (In years;  
last birthday)

*63*

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Maintenance Man*

10B. KIND OF BUSINESS OR INDUSTRY

*Wholesale Drugs*

11. BIRTHPLACE (State or foreign country)

*Balto. Md.*

12. CITIZEN OF  
WHAT COUNTRY?

*USA.*

13. FATHER'S NAME

*Charles Rossman*

14. MOTHER'S MAIDEN NAME

*Margaret Wombold*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL  
SECURITY NO.

*215-01-6898*

17. INFORMANT

ADDRESS

*Mrs. Charles Prody 1011 Quantril Way*

18. *443 X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

*Arterio Sclerotic Hypertensive  
Cardio Vascular Disease*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from *3/23*, 19*50* to *3/24*, 19*50*; that I last saw the deceased alive on *3/24*, 19*50*, and that death occurred at *7A* m., from the causes and on the date stated above.

23A. SIGNATURE

*John H. Hanzl*

M. D.

23B. ADDRESS

*Mercy Hospital*

23C. DATE SIGNED

*3/24/50*

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

*Burial*

24B. DATE

*3/27/50*

24C. NAME OF CEMETERY OR CREMATORY

*Loudon Park Cem.*

24D. LOCATION (City, town, or county)

*Balto., Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

*MAR 25 1950*

REGISTRAR'S SIGNATURE

*Wm. J. Tickner & Sons*

25. FUNERAL DIRECTOR

*WM. J. TICKNER & SONS*

ADDRESS

*Balto., Md.*



REPUBLIC OF THE PHILIPPINES  
OFFICE OF THE SECRETARY OF DEFENSE

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1975



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

LEON R. FOUCH

2. DATE  
OF  
DEATH

Mar. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5204 Fernpark Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Immigration Officer

10B. KIND OF BUSINESS OR INDUSTRY

U. S. Gov't.

13. FATHER'S NAME

- Fouch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Alton E. Fouch

5204 Fernpark Ave.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

MYOCARDIAL DEGENERATION

3 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

HYPERTENSION

15 YEARS

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

CIRRHOSIS OF LIVER, CHRONIC

1 YEAR

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1935, 19, to March 24, 1950, that I last saw the deceased alive on Mar. 23, 1950, and that death occurred at 8:55 A.M., from the causes and on the date stated above.

23A. SIGNATURE

W. Hoffmann, M.D.

M. D.

23B. ADDRESS

8 East Reed Street

23C. DATE SIGNED

3/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 25 1950

REGISTRAR'S SIGNATURE

W. Hoffmann, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. TIGKNER & SONS

Balto., Md.

VS 150

10497

124B



STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that \_\_\_\_\_

of the County of \_\_\_\_\_ State of \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the true and correct copy of \_\_\_\_\_

as the same appears from the \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

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\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

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\_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

235  
50 2760  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2760  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Robert Irving Costin</b>			2. DATE OF DEATH <b>3/24/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore, Md.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 30 25-02B</b>		
C. Length of stay in Baltimore Yrs. Mos. Days <b>2509 Brohawn Ave.</b>			D. STREET ADDRESS (If rural, give location)		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11/31/1886</b>	9. AGE (In years last birthday) <b>64</b>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Core Maker</b>			10B. KIND OF BUSINESS OR INDUSTRY (Brass) <b>(Machine) Baltimore, Md.</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>James M. Costin</b>			14. MOTHER'S MAIDEN NAME <b>Madora E. Ziemer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-03-7183</b>		
17. INFORMANT <b>Mrs. Lydia A. Costin</b>			ADDRESS <b>2509 Brohawn Ave.</b>		
18. <b>196X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <b>(A) <del>Spine with metastases to left radius &amp; ulna</del> <i>osteogenic sarcoma of spine with metastases to left radius &amp; ulna</i></b> <b>(B) <i>&amp; adrenal glands.</i></b> <b>(C)</b>		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/21/50</b> , 19__, to <b>3/24/50</b> , 19__, that I last saw the deceased alive on <b>3/24/50</b> , 19__, and that death occurred at <b>10:40 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>John C. Surry</i>			23B. ADDRESS <b>1213 Light Street</b>		23C. DATE SIGNED <b>3/24/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/28/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 25 1950</b>		REGISTRAR'S SIGNATURE <i>Wm. J. Tickner</i>		25. FUNERAL DIRECTOR <b>WM. J. TICKNER &amp; SONS</b>	
				ADDRESS <b>Balto., Md.</b>	

VS 150

49637

5413



BRANCH OF WEST VIRGINIA  
CERTIFICATE OF DEATH

FILE NO.  
DATE

NAME OF DECEASED  
AGE  
SEX  
RACE  
BIRTH DATE

1. Name of Deceased: [Illegible]  
2. Age: [Illegible]  
3. Sex: [Illegible]  
4. Race: [Illegible]  
5. Birth Date: [Illegible]  
6. Date of Death: [Illegible]  
7. Place of Death: [Illegible]  
8. Cause of Death: [Illegible]  
9. Signature of Physician: [Illegible]  
10. Signature of Registrar: [Illegible]  
11. Date of Registration: [Illegible]



correct age is especially important. Physicians please write the causes of death clearly and legibly.

S-530  
50 2761

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2761  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Louise Smith</i>		2. DATE OF DEATH <i>3-23-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>16-02</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>President Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>life</i>		D. STREET ADDRESS (If rural, give location) <i>1427 Laurens</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>12/25/1879</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nathan Queen</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John Haliburton</i>		ADDRESS <i>1427 Laurens</i>	

18. <i>337X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Hypostatic pneumonia</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	(B) <i>Cerebral thrombosis</i> DUE TO <i>??</i>	(C) <i>Essential hypertension</i> <i>Diabetes mellitus, uncontrolled</i> <i>??</i>
--	---	--

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3-17</i> , 19 <i>50</i> , to <i>3-23</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-23</i> , 19 <i>50</i> , and that death occurred at <i>4:00</i> p. m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Louise W. Leeper, M.D.</i>		23B. ADDRESS <i>President Hosp.</i>		23C. DATE SIGNED <i>3-28-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/27/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St Peter</i>	
24D. LOCATION (City, town, or county) <i>md</i>		24E. FUNERAL DIRECTOR <i>1303</i>		24F. ADDRESS <i>Prussman St</i>	

MAR 25 1950  
VS 150



DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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416

50 2762

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2762

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARIE ALBERT

2. DATE  
OF  
DEATH

March 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1817 E. 29th. Street

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

1817 E. 29th. Street

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

B. &amp; O. R. R. Co.

8. DATE OF BIRTH

Dec. 9, 1901

9. AGE (in years  
last birthday)

48

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Albert

14. MOTHER'S MAIDEN NAME

Mamie Blessing

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

705-05-2872

17. INFORMANT 1817 E. 29th. Street

Mrs. Margaret Puhl

18. 481X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

3/23/50

ANTECEDENT CAUSES

(B)

Flu

3/17/50

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 3/21, 1950, to 3/23, 1950, that I last saw the  
deceased alive on 3/21, 1950, and that death occurred at 12:45 A. M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

PARKWOOD CEMETERY

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 25 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

HENRY SANDER &amp; SONS, INC.

BALTIMORE - 13, MD.

VS 150

26647

94a

The correct age is especially important. Physicians write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL. 733-4331  
CIRCULAR 100  
JAN 1964

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL. 733-4331  
CIRCULAR 100  
JAN 1964

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL. 733-4331  
CIRCULAR 100  
JAN 1964

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL. 733-4331  
CIRCULAR 100  
JAN 1964



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2763  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FRANK WILLIAM MILLER

2. DATE  
OF  
DEATH

Mar. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 9-06

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

1310 E. 31st. Street

D. STREET ADDRESS (If rural, give location)  
1610 E. 31st. Street

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Sept. 10, 1886

9. AGE (in years last birthday)

63

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Bank

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank W. Miller

14. MOTHER'S MAIDEN NAME

Elizabeth Miersch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

216-24-3829

17. INFORMANT 1610 E. 31st. Street -18

Mrs. Bertha M. Miller

18.

443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUPLICATE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUPLICATE

(C)

INTERVAL BETWEEN ONSET AND DEATH

2 yrs -  
(?)  
10 yrs -

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 to March 22, 1950, that I last saw the deceased alive on 3/21, 1950, and that death occurred at 9:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 25 1950

REGISTRAR'S SIGNATURE

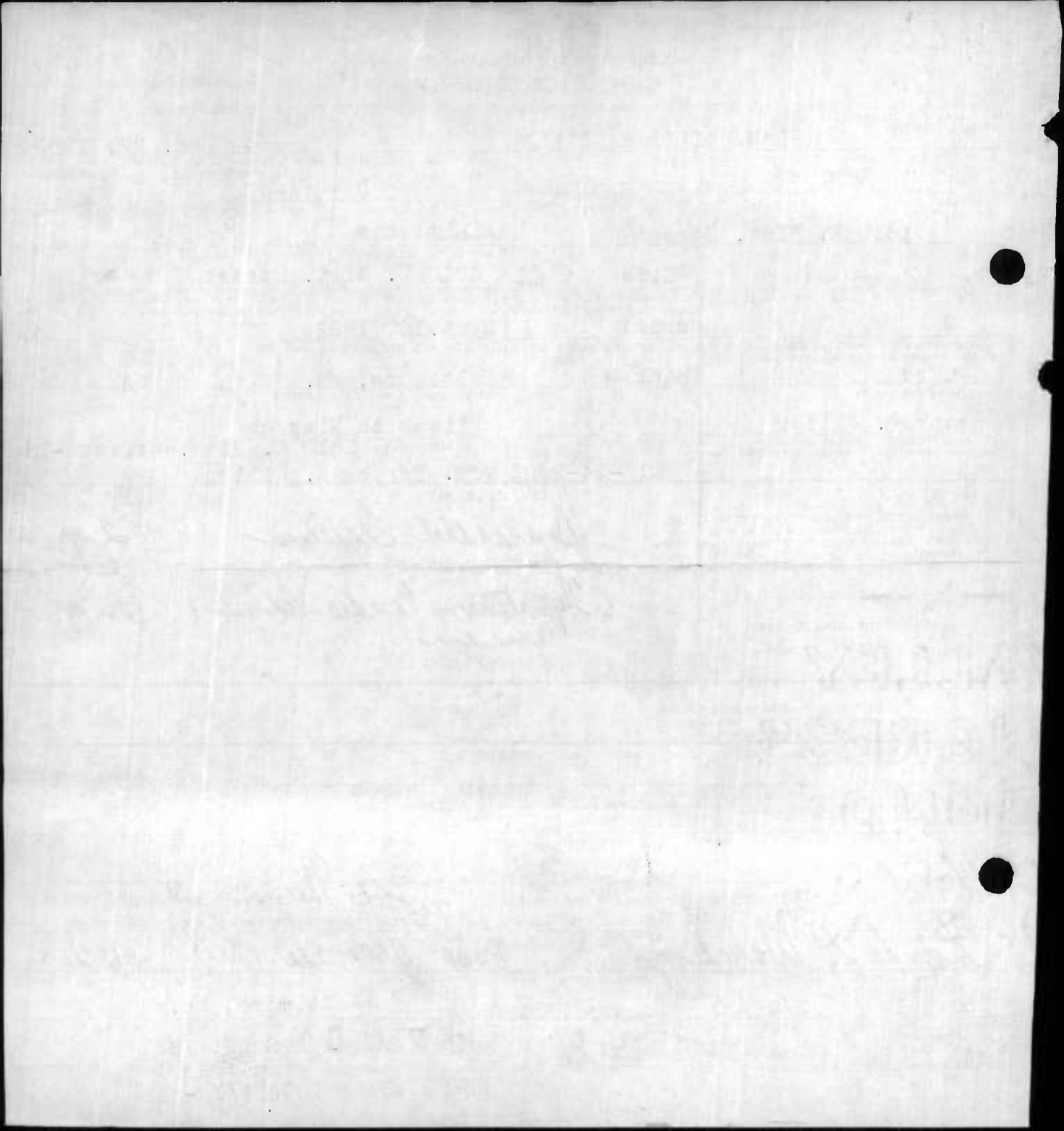
Thurston W. Williams, Jr.

25. FUNERAL DIRECTOR

CHERRY SANDER & SONS, INC

ADDRESS







200  
276  
135550  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH  
Registered No. 50 2764  
BIRTH NO.  
1. NAME OF DECEASED  
(Type or Print)  
Peter Voci  
3. PLACE OF DEATH:  
A. Baltimore City, Maryland  
B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.  
Length of stay in Baltimore 30 yrs.  
Yrs. Mos. Days  
5. SEX Male  
6. COLOR OR RACE White  
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Sep.  
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
CARPENTER  
10B. KIND OF BUSINESS OR INDUSTRY  
CONSTRUCTION  
11. BIRTHPLACE (State or foreign country)  
Italy  
12. CITIZEN OF WHAT COUNTRY?  
13. FATHER'S NAME  
Joseph Voci  
14. MOTHER'S MAIDEN NAME  
Victoria  
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  
(If yes, give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT  
B. C. H. Records  
ADDRESS  
18. 4201  
CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
Coronary Thrombosis  
(A) DUE TO  
ANTECEDENT CAUSES  
(B) DUE TO  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
(C) DIABETES MELLITUS  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
19A. DATE OF OPERATION  
19B. MAJOR FINDINGS OF OPERATION  
20. AUTOPSY?  
YES ☐ NO ☒  
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21F. HOW DID INJURY OCCUR?  
22. I hereby certify that I attended the deceased from 2-6-50, 1950, Mar. 23, 1950, that I last saw the deceased alive on Mar. 23, 1950, and that death occurred at 8AM m., from the causes and on the date stated above.  
23A. SIGNATURE  
23B. ADDRESS  
4940 Eastern Ave.  
23C. DATE SIGNED  
2-23-50  
24A. BURIAL, CREMATION, REMOVAL (Specify)  
24B. DATE  
3-25-50  
24C. NAME OF CEMETERY OR CREMATORY  
24D. LOCATION (City, town, or county) (State)  
DATE RECEIVED BY LOCAL REGISTRAR  
MAR 25 1950  
REGISTRAR'S SIGNATURE  
VS 150  
308 V9  
322 S. High St. 61

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Peter Voci

2. DATE  
OF  
DEATH

3-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 26-12

D. STREET ADDRESS (If rural, give location)

Homeless- B. C. H. Infirmary

Length of stay in Baltimore 30 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Sep.

8. DATE OF BIRTH

May 26, 1886

9. AGE (in years last birthday)

63

10. Under 1 Year Months: Days  
11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Voci

14. MOTHER'S MAIDEN NAME

Victoria

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

B. C. H. Records

ADDRESS

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-6-50, 1950, Mar. 23, 1950, that I last saw the deceased alive on Mar. 23, 1950, and that death occurred at 8AM m., from the causes and on the date stated above.

23A. SIGNATURE

*[Signature]*

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

2-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

3-25-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 25 1950

REGISTRAR'S SIGNATURE

*[Signature]*

25. FUNERAL DIRECTOR

ADDRESS

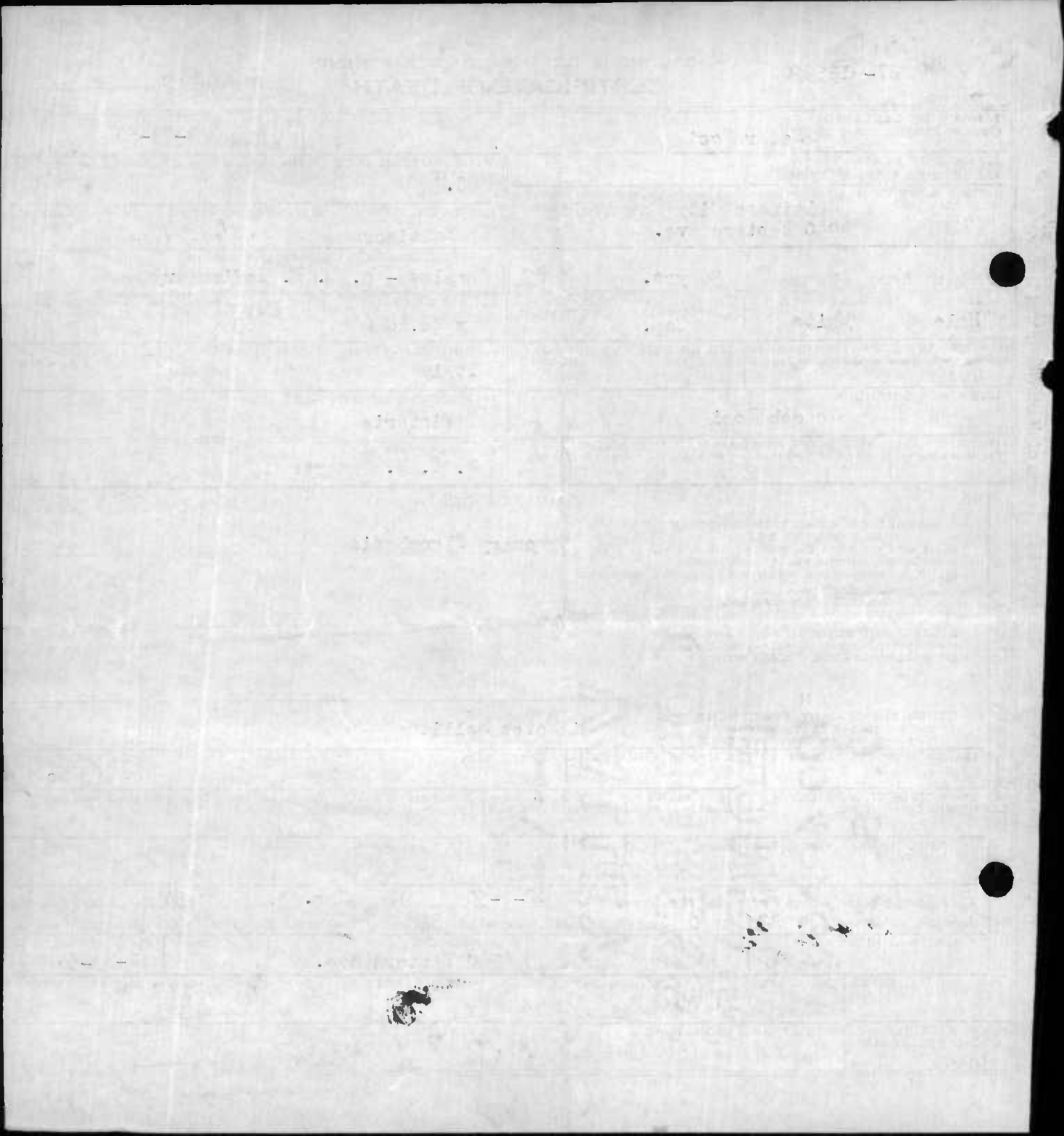
*[Signature]*

VS 150

308 V9

322 S. High St. 61







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Frank Morton

2. DATE  
OF  
DEATH

3- 24- 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

829 Edmondson Ave. Z 1

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 21- 1880 ?

9. AGE (In years last birthday)

69 Yrs.

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Travel Agent

10B. KIND OF BUSINESS OR INDUSTRY

B & O

13. FATHER'S NAME

Henry Morton

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF WHAT COUNTRY?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. 150X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Of Esophagus

DEVELOPED with

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Atelectasis of lungs due to Stricture of trachea

DUE TO

CERTIFICATION APPROVED BY

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Esophagoscopy

CHIEF OR ASST. MEDICAL EXAMINER

20. AUTOPSY?

YES ☒ NO ☐

19A. DATE OF OPERATION

3- 24- 1950.

19B. MAJOR FINDINGS OF OPERATION

Esophagoscopy

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Balto. City Hospital, 4940 Eastern Ave.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

March 24, 1950 10 A.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Patient died immediately following esophagoscopy under pontocaine anesthesia

22. I hereby certify that I attended the deceased from 3- 17- 1950, to 3- 24- 1950, that I last saw the deceased alive on 3- 24- 1950 and that death occurred at 10.45 A.M. from the causes and on the date stated above.

23A. SIGNATURE

*J. H. Cohen*

M. D.

23B. ADDRESS

B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED

3- 24- 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/28/50

24C. NAME OF CEMETERY OR CREMATORY

mt - Auburn

24D. LOCATION (City, town, or county)

Westport, Balty. md -

DATE RECEIVED BY LOCAL REGISTRAR

MAR 25 1950

REGISTRAR'S SIGNATURE

*William H. Williams*

25. FUNERAL DIRECTOR

ADDRESS

*Metropolitan Funeral Home Inc*

VS 150

To Be Approved By The Chief Medical Examiner.

988 47

927. Morton

46a

Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







What age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2766  
Registered No. 50 2766

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROSARIA MAGGIO</b>		2. DATE OF DEATH <b>March 23, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>805 E. Belvedere Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>805 E. Belvedere Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Md. 27-08B</b>	
D. STREET ADDRESS (If rural, give location)			
Length of stay in Baltimore <b>46</b> Yrs. Mos. Days			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, <del>WIDOWED</del> DIVORCED (Specify)	8. DATE OF BIRTH <b>1880</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Confectionery</b>	9. AGE (In years, last birthday) <b>70</b>
13. FATHER'S NAME <b>ROSARIO MAGGIO</b>		11. BIRTHPLACE (State or foreign country) <b>Sicily, Italy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>ROSARIA MAGGIO</b>	
17. INFORMANT <b>Rose LaDecca</b>		ADDRESS <b>1107 Andover Rd.</b>	

MEDICAL CERTIFICATION	18. <b>443X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Congestive heart failure</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension, arterial</b> DUE TO		<b>18 yrs.</b>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Generalized arteriosclerosis</b> DUE TO		<b>?</b>
	19A. DATE OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	19B. MAJOR FINDINGS OF OPERATION		
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
	22. I hereby certify that I attended the deceased from <b>Feb 20</b> , 1947, to <b>Mar 23</b> , 1950, that I last saw the deceased alive on <b>Mar 22</b> , 1950, and that death occurred at <b>3 A. m.</b> , from the causes and on the date stated above.		
	23A. SIGNATURE <b>Francis J. Vollmer</b> M. D.		23B. ADDRESS <b>6100 York Road</b>
	23C. DATE SIGNED <b>Mar. 25, 1950</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>March 27, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Balt. Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 25 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. ...</b>	
25. FUNERAL DIRECTOR <b>Joseph ... Inc.</b>		ADDRESS <b>2013 Hammond Ave</b>	



STATE OF CALIFORNIA

County of \_\_\_\_\_

No. \_\_\_\_\_

Know all men by these presents, that \_\_\_\_\_ of the County of \_\_\_\_\_ State of California, for and in consideration of the sum of \_\_\_\_\_ Dollars, to \_\_\_\_\_ in hand paid by \_\_\_\_\_ the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said \_\_\_\_\_ of the County of \_\_\_\_\_ State of California, all that certain \_\_\_\_\_

TO HAVE AND TO HOLD unto the said \_\_\_\_\_ heirs and assigns forever.

And the said \_\_\_\_\_ do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of \_\_\_\_\_ State of California.

Witness my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 19\_\_\_\_.

Notary Public for the State of California.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 2757**

BIRTH NO. **50 2757**

1. NAME OF DECEASED  
(Type or Print)

*Mary Hurley*

2. DATE OF DEATH

*March 24, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore Md.*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*2014 E. Fayette Street*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

*6-04*

D. STREET ADDRESS (If rural, give location)

*2014 E Fayette Street*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*April 8, 1889*

9. AGE (In years last birthday)

*60*

10. Under 1 Year Months: Days: Hours: Min.

*11 16*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore Maryland*

12. CITIZEN OF WHAT COUNTRY?

*U. S.*

13. FATHER'S NAME

*George Robertson*

14. MOTHER'S MAIDEN NAME

*Ella Decubard*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*none*

17. INFORMANT

ADDRESS

*Edward M. Hurley 2612 Oakland Ave*

18. *447X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Acute Cardiovascular Failure*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*30 min.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arteriosclerotic - Cardio -*

DUE TO

*vascular Renal Disease*

*5 yrs.*

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 24, 1948* to *March 23, 1950*, that I last saw the deceased alive on *March 23, 1950*, and that death occurred at *4 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Israel Rosen*

23B. ADDRESS

*2413 E Monument St*

23C. DATE SIGNED

*3/25/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 28, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer Cemetery*

24D. LOCATION (City, town, or county)

*4430 Belair Rd Balto. Md.*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 25 1950*

REGISTRAR'S SIGNATURE

*William H. Williams*

25. FUNERAL DIRECTOR

*Joseph J. Isaac, Inc. 1133 Guilford Ave*

ADDRESS

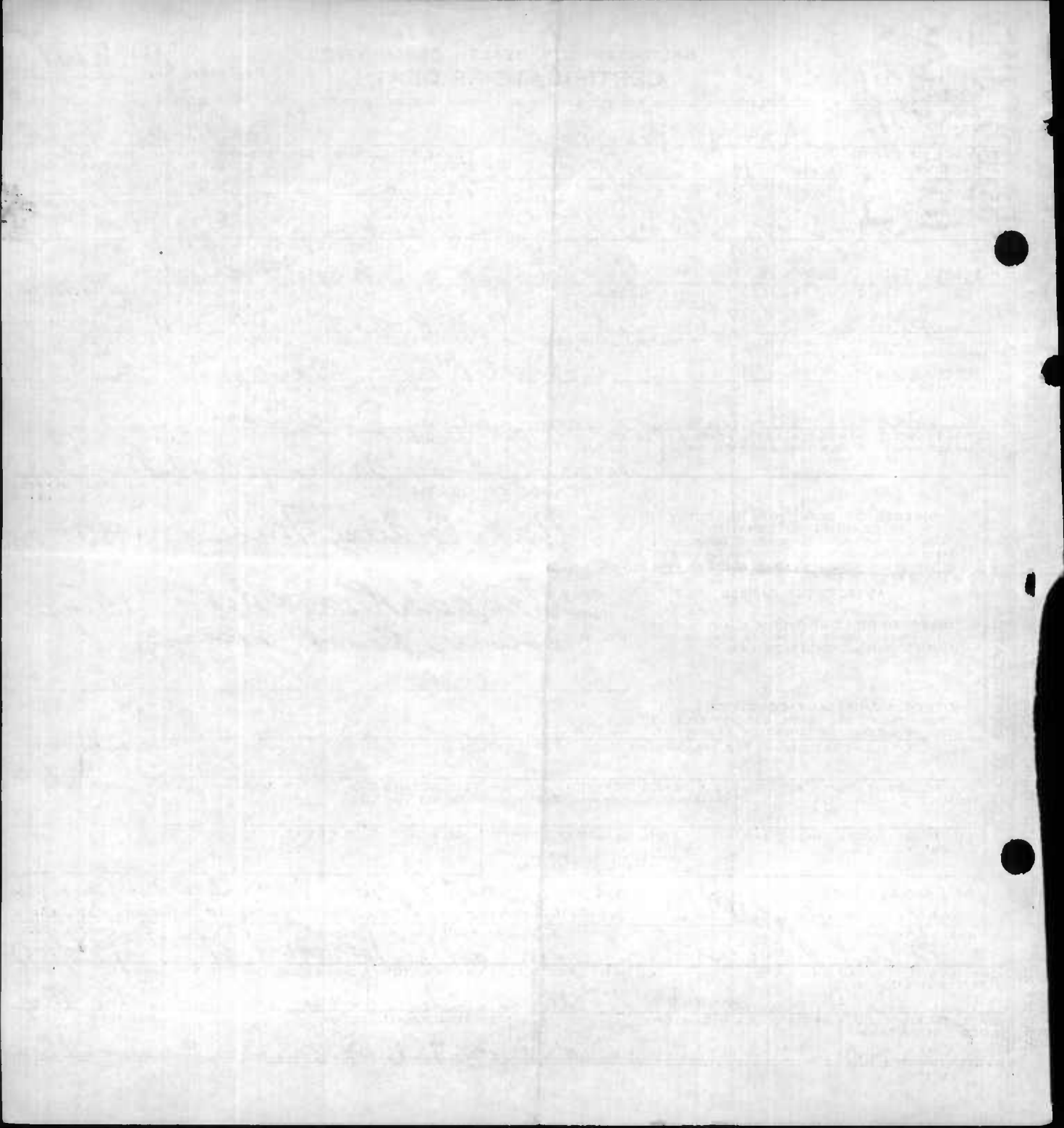
VS 150

*131a*

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please state the causes of death clearly and legibly.

MEDICAL CERTIFICATION







PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2768

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FRANK ANDRYCHOWSKI

2. DATE  
OF  
DEATH

March 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

247 S. Regester Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

2-02

D. STREET ADDRESS (If rural, give location)

247 S. Regester Street

C. Length of stay in Baltimore

50 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 21, 1876

9. AGE (In years  
last birthday)

73

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Shoemaker - Ret.

10B. KIND OF BUSINESS OR  
INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Andrychowski

14. MOTHER'S MAIDEN NAME

Mary Partykula

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

--

17. INFORMANT

ADDRESS

Mr. Walter Krawczyk, 247 S. Regester Street

18.

443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

TERMINAL BRONCHO-PNEUMONIA

2 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A), STATING THE  
UNDERLYING CONDITION LAST.

(B)

CEREBRAL HEMORRHAGE

3/19/50

DUE TO

ARTERIOSCLEROTIC HYPERTENSIVE  
(C) CARDIO-VASCULAR DISEASE

3/30/50

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

22. I hereby certify that I attended the deceased from MARCH 30, 1948, to MARCH 22, 1950, that I last saw the  
deceased alive on MAR. 22, 1950, and that death occurred at 9:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph F. Dranga

M. D.

23B. ADDRESS

209 S. Chester St.

23C. DATE SIGNED

3/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

March 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, town, county)

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christina M. O'Donnell

25. FUNERAL DIRECTOR

ADDRESS

M. J. Radowski & Sons, 1808 Eastern Avenue

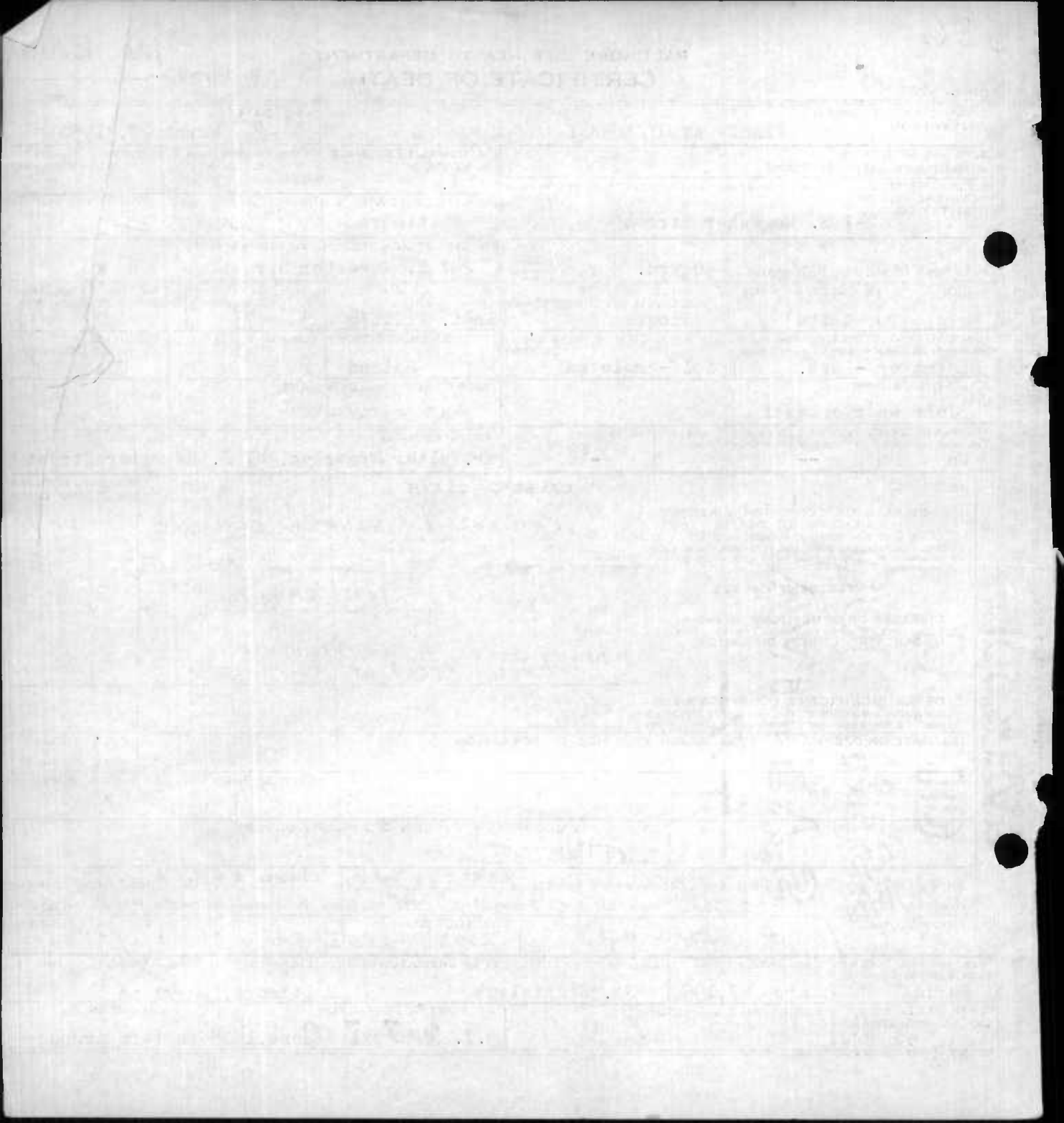
MAR 25 1950

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93)







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2769  
Registered No.

1. NAME OF DECEASED (Type or Print) *Peter Benson*

2. DATE OF DEATH *3/24/50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE *Maryland* B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
*St. Agnes Hospital*

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 28-04*

7. STREET ADDRESS (If rural, give location)  
*5002 West Hills Rd. PKWY*

8. Length of stay in Baltimore *3* Yrs. *3* Mos. *0* Days

9. SEX *M* 10. COLOR OR RACE *W* 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widowed*

12. DATE OF BIRTH *9/8/1863* 13. AGE (In years last birthday) *86* 14. If Under 1 Year Months: Days 15. If Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Office Clerk* 17. KIND OF BUSINESS OR INDUSTRY *Armour + Company*

18. BIRTHPLACE (State or foreign country) *Sweden* 19. CITIZEN OF WHAT COUNTRY? *U. S. A.*

20. FATHER'S NAME *Peter Benson (dec'd)* 21. MOTHER'S MAIDEN NAME *Mabel R. Benson (dec'd)*

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *No* 23. SOCIAL SECURITY NO. *Same -*

18. *443X* CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Congestive heart failure* 19. INTERVAL BETWEEN ONSET AND DEATH *1 month*

ANTECEDENT CAUSES

(B) *Arteriosclerotic Hypertensive* 20. ? yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) *CVD*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3/23*, 19*50*, to *3/24*, 19*50*, that I last saw the deceased alive on *3/24*, 19*50*, and that death occurred at *7:50* a. m., from the causes and on the date stated above.

23A. SIGNATURE *Robert J. Levickas* M. O. 23B. ADDRESS *St. Agnes Hospital* 23C. DATE SIGNED *3/24/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *28-MAR-50* 24C. NAME OF CEMETERY OR CREMATORY *Grace Land Park* 24D. LOCATION (City, town, or county) (State) *Sioux City - IOWA.*

DATE RECEIVED BY LOCAL REGISTRAR *MAR 25 1950* REGISTRAR'S SIGNATURE *H. D. Wyckoff* 25. FUNERAL DIRECTOR *H. D. Wyckoff* ADDRESS *1300 East Main Pl*



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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-500

50 2770

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50 2770

1. NAME OF DECEASED (Type or Print) <i>Carrie Seim</i>		2. DATE OF DEATH <i>3/24/50 9:30 a.m.</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>243 W. 31st St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 12-06</i>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>243 W. 31st St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/30/1868</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	9. AGE (in years last birthday) Months: Days: Hours: Min: <i>81</i>
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Christian Beyer</i>		14. MOTHER'S MAIDEN NAME <i>Dorothea Beck</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Paul J. Prosser</i>		ADDRESS <i>25 S. Calvert St.</i>	

18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) I <i>Anterior Septic Heart Disease</i>	CAUSE OF DEATH (A) <i>Anterior Septic Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

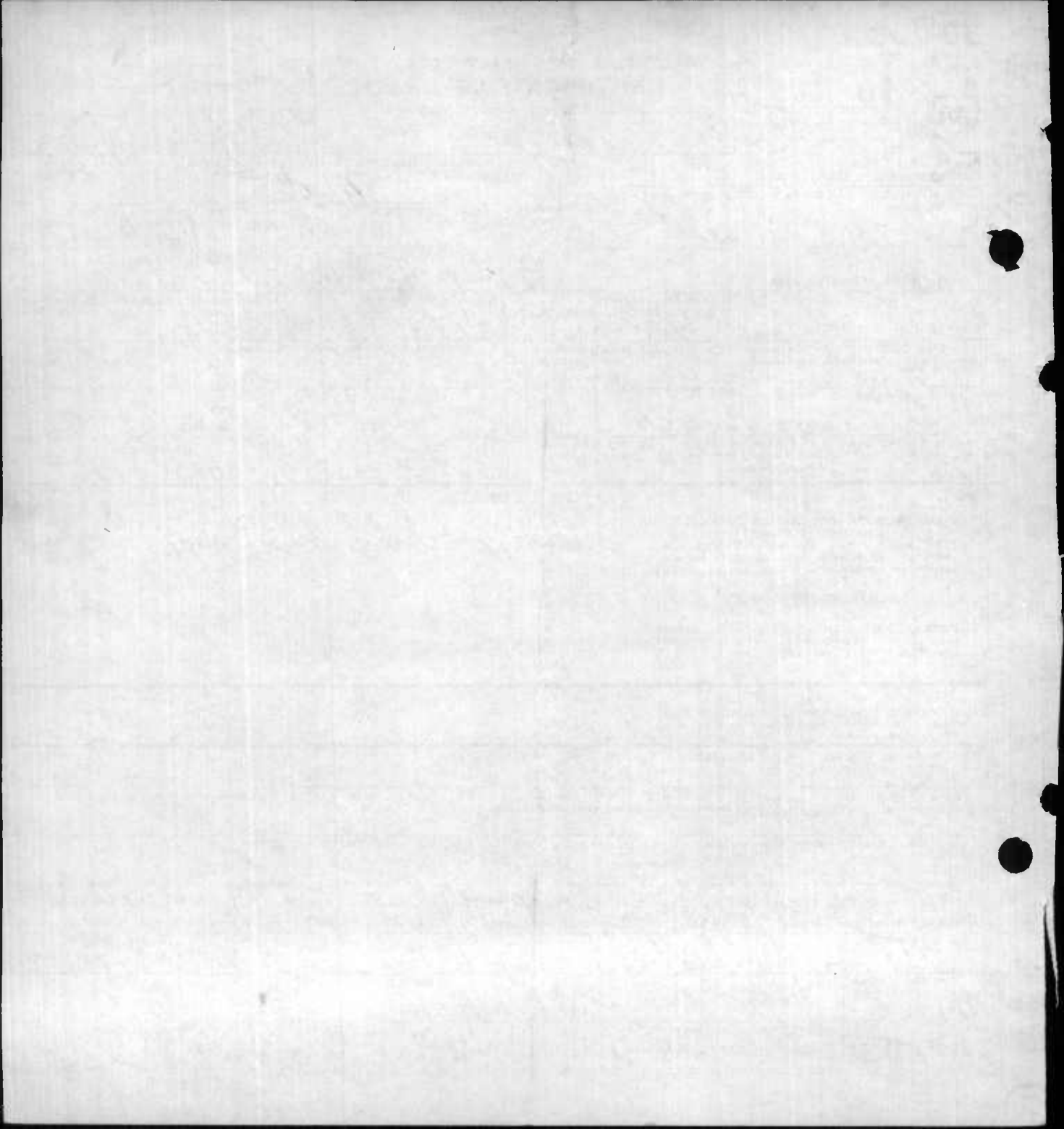
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 22, 1950</i> , to <i>Mar. 24, 1950</i> , that I last saw the deceased alive on <i>March 23, 1950</i> , and that death occurred at <i>9:30 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Crawford N. Kihlpatrick Jr.</i>		23B. ADDRESS <i>6 E. Eager St. Baltimore</i>		23C. DATE SIGNED <i>3-25-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25. FUNERAL DIRECTOR <i>Am 206K Inc.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 25 1950</i>		REGISTRAR'S SIGNATURE <i>W. J. ...</i>		ADDRESS <i>1217 St. Paul St.</i>	

VS 150

MAR 25 1950

93D







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2771  
Registered No.

400  
BIRTH NO. 2771

1. NAME OF DECEASED (Type or Print) <b>CHRISTOPHER CHARLES COLE</b>		2. DATE OF DEATH <b>March 24, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Marine Hospital</b> <b>Wyman Pk. Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>7-04</b>	
D. STREET ADDRESS (If rural, give location) <b>1041 N. Broadway</b>		5. Yrs. Mos. Days	
c. Length of stay in Baltimore <b>?</b>		6. Yrs. Mos. Days	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 27, 1881</b>
9. AGE (In years last birthday) <b>68</b>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. BIRTHPLACE (State or foreign country) <b>Ill.</b>	
13. CITIZEN OF WHAT COUNTRY? <b>USA</b>		14. FATHER'S NAME <b>James B. Cole</b>	
15. MOTHER'S MAIDEN NAME <b>?</b>		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>	
17. SOCIAL SECURITY NO. <b>?</b>		18. ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>	

18. <b>4/20-1</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <b>Arteriosclerotic Coronary artery Disease</b>	
ANTECEDENT CAUSES	(B) <b>Atelectasis Left Lung</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) <b>Pleural Effusion Bilateral</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>?</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Mar. 20**, 19**50**, to **Mar. 24**, 19**50**, that I last saw the deceased alive on **Mar. 24**, 19**50**, and that death occurred at **10:30 A** m., from the causes and on the date stated above.

23A. SIGNATURE **William Bromwich** M. D. 23B. ADDRESS **US Marine Hospital, Balto, Md.** 23C. DATE SIGNED **3/24/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/28/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>U. S. National</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>1227 Park Dr</b>	ADDRESS <b>1217 St. Paul St.</b>

MAR 25 1950

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

MASSACHUSETTS

Worcester

John H. Stoughton

May 2, 1961

11

Worcester - St. Vincent's Hospital

Yes

John H. Stoughton

John H. Stoughton  
Worcester, Mass. 01601

John H. Stoughton, 11, Worcester, Mass.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be written clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2772  
Registered No.

300  
50 2772  
BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Bailey S.		Goode (E.H.)		2. DATE OF DEATH March 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1639 Pentwood Rd.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-09			
D. STREET ADDRESS (If rural, give location) 1639 Pentwood Rd.				E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 10-1898		9. AGE (In years last birthday) 51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Electric		10B. KIND OF BUSINESS OR INDUSTRY US Marine Corps		11. BIRTHPLACE (State or foreign country) Mechanicville Md		12. CITIZEN OF WHAT COUNTRY? Md	
13. FATHER'S NAME John Ludoms Goode				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			

MEDICAL CERTIFICATION

18. E976 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH Bullet wound of Brain DUE TO (B) Carcinoma of Rectum	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1639 Pentwood Rd.
21D. TIME (Month) (Day) (Year) (Hour) March 24, 1950 6:10 am	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Firearms
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		

23A. SIGNATURE Earl L. Ryer	23B. CHIEF MEDICAL EXAMINER M.D. MEDICAL INVESTIGATOR	23C. DATE SIGNED 27 Mar 50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/27/50	24C. NAME OF CEMETERY OR CREMATORY Roland
24D. LOCATION (City, town, or county) (State) Baltimore Md	25. FUNERAL DIRECTOR 27 Mar 50	ADDRESS 1640 Roland St

MAR 25 1950

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CERTIFICATE OF DEATH

STATE OF

DEPARTMENT OF HEALTH

CITY OF

DATE

TIME

PLACE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 2773**

**BIRTH NO.** **2773**

<b>1. NAME OF DECEASED</b> (Type or Print) <b>CHARLES H. RUPERTI (RUPERT) (E/W)</b>		<b>2. DATE OF DEATH</b> <b>March 22, 1950</b>	
<b>3. PLACE OF DEATH:</b> <b>A. Baltimore City, Maryland</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b>	
<b>B. FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>Mercy Hospital</b>		<b>C. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
<b>D. Length of stay in Baltimore</b> Yrs. Mos. Days		<b>E. STREET ADDRESS</b> (If rural, give location) <b>160 N. Gay Street</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>1874</b>
<b>9. AGE</b> (In years last birthday) <b>75</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore Md</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <b>Anthony B. Rupert</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Cook</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <b>No</b>	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Catherine Rupert, 3022 Kentucky Ave</b>	

<b>18. CAUSE OF DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) Myocardial Inefficiency</b> <b>arteriosclerotic cardiovascular disease</b>		
<b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b> <b>(B)</b>		
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <b>(C)</b>		

<b>19A. DATE OF OPERATION</b>		<b>19B. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/>, accident <input type="checkbox"/>, suicide <input type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.</b>				
<b>23A. SIGNATURE</b> <b>R. B. Fisher</b>		<b>23B. CHIEF MEDICAL EXAMINER.....</b> <input checked="" type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER.....</b> <input type="checkbox"/> M.D.		<b>23C. DATE SIGNED</b> <b>3/23/50</b>
<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Buried</b>	<b>24B. DATE</b> <b>3/28/50</b>	<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>St. Johns</b>		<b>24D. LOCATION (City, town, or county) (State)</b> <b>Baltimore Md</b>
<b>DATE RECEIVED BY LOCAL REGISTRAR</b> <b>Mar 24 1950</b>		<b>REGISTRAR'S SIGNATURE</b> <b>William H. Miller</b>		<b>25. FUNERAL DIRECTOR</b> <b>William H. Miller</b>
<b>ADDRESS</b> <b>1214 St. Paul St</b>				

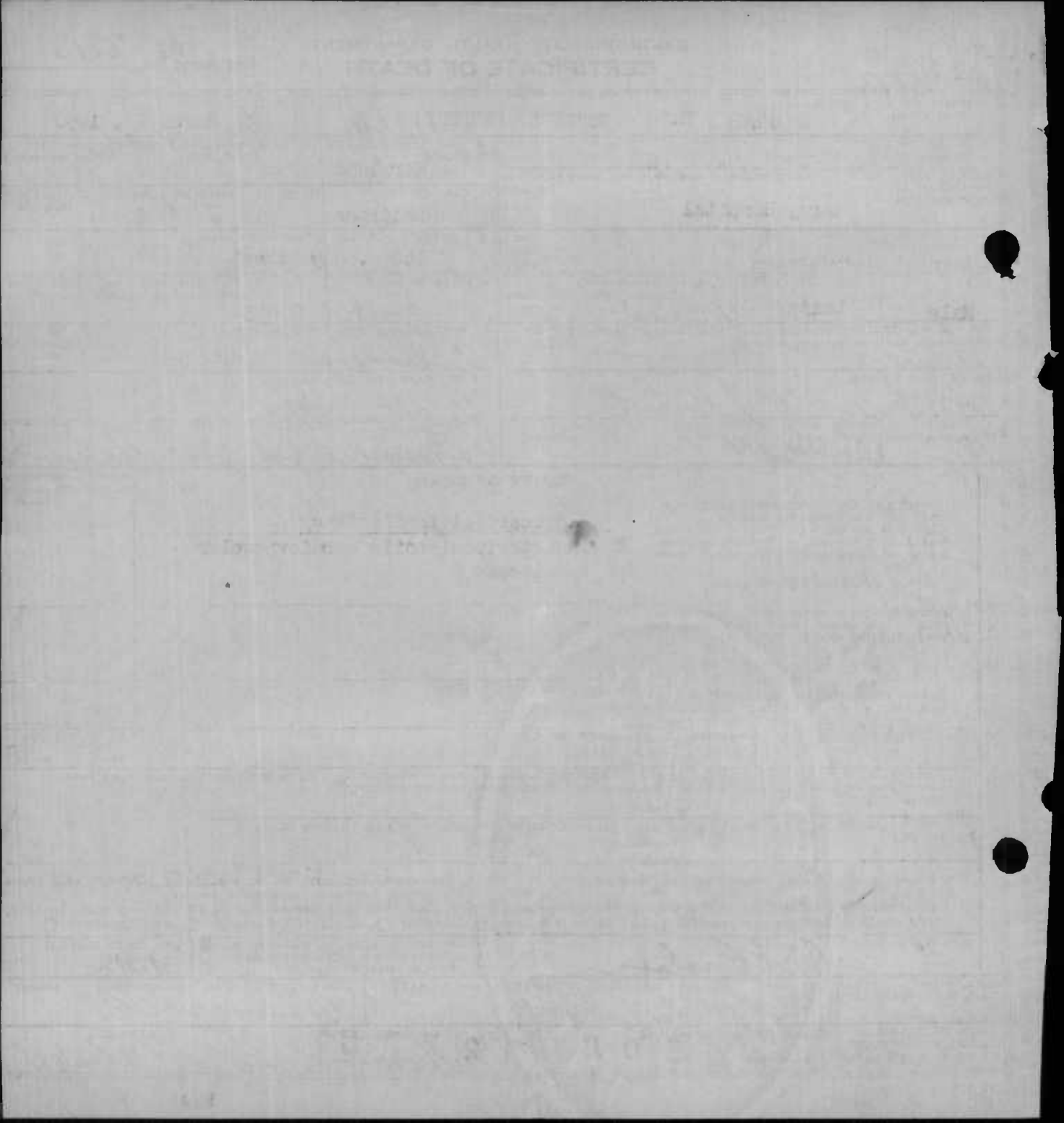
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**MAR 25 1950**

93D V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2774  
Registered No.

652  
BIRTH NO. 2774

1. NAME OF DECEASED (Type or Print) <b>JOHN NAIRNS</b>		2. DATE OF DEATH <b>March 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>918 E. Biddle Street</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept 24, 1893</b>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Son of Thomas</b>		9B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	9. AGE (In years last birthday) <b>56</b>
10. CITIZEN OF WHAT COUNTRY?		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Thomas Nairns</b>		14. MOTHER'S MAIDEN NAME <b>Sabina McKeever</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Thomas Nairns, 1918 E. Biddle St</b>		ADDRESS	

18. <b>4201</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

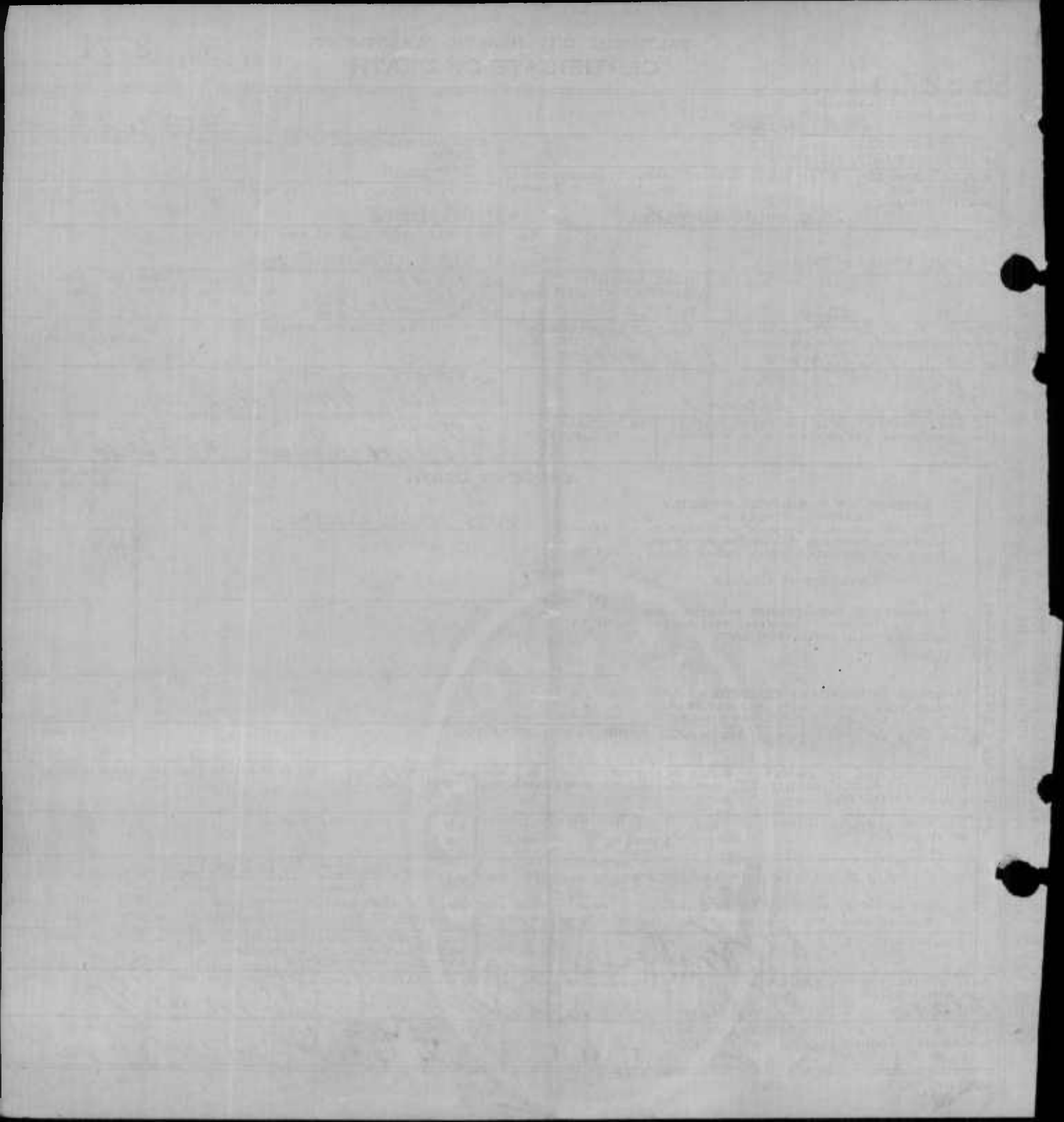
22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>Robert Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>March 8, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>	24B. DATE <b>3/27/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>Thomas Nairns, 1918 E. Biddle St</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 24 1950</b>		REGISTRAR'S SIGNATURE <b>William H. B. 500</b>		

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MAR 25 1950  
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PLEASE WRITE IN INK. Every item of information should be clearly and correctly stated. Physicians: please write the causes of death clearly and correctly. Correct age is especially important.







BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No. **50 2775**

BIRTH NO. **2775 48-23913**

1. NAME OF DECEASED (Type or Print) <b>SHARON Lee HART</b>		2. DATE OF DEATH <b>March 24, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>5003 Walter Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Abltimore 27-01</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>5003 Walter Avenue</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Nov. 1-1948</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days <b>1 4</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Francis C. Hart</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rita Kaufman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr Francis Hart</b>		ADDRESS <b>2708 Cheshire</b>	

18. <b>391.6 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute otitis media with septicemia</b> <b>due to streptococcus salivarius and hemolyticus</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <b>H. J. Mc Clafferty</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER.....		23C. DATE SIGNED <b>3-24-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/27/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 25 1950</b>		REGISTRAR'S SIGNATURE <b>L. J. Kuck</b>		25. FUNERAL DIRECTOR <b>5305 Hayford Rd</b>

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



Every item of information should be carefully supplied. The cause of death clearly and briefly. Physicians: please write the causes of death clearly and briefly. Correct age is especially important.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

2776 49-27479

50 2776

1. NAME OF DECEASED  
(Type or Print)

CARVER LEROY GILL, JR.

2. DATE  
OF  
DEATH

3-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4206 FURLEY AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE MD.

B. COUNTY 16-02 before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution)

4206 FURLEY AVE.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE, MD

D. STREET ADDRESS (If rural, give location)

4206 FURLEY AVE

c. Length of stay in Baltimore

3 Yrs.  
10 Mos.  
30 Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

DEC 15, 1949

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days  
3 1010A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baito Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CARVER LEROY GILL

14. MOTHER'S MAIDEN NAME

SHIRLEY WARM BOLD

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

MOTHER

ADDRESS

SAME

18. 751X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

RESPIRATORY FAILURE

BRIEF

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

HYDROCEPHALUS

LIFE

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

MENINGOCELE

LIFE

TALIPES EQUINO VAXUS (BILATERAL)

PARALYSIS LOWER EXTREMITIES

LIFE

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 3, 1950 to Mar 25, 1950, that I last saw the deceased alive on Mar 7, 1950, and that death occurred at 7:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Mary P. Haylock

M. D.

23B. ADDRESS

229 E. 33rd St.

23C. DATE SIGNED

3-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Balt Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

L. J. Krick

25. FUNERAL DIRECTOR

ADDRESS

L. J. Krick - 5305 Hayford Rd

VS 150

157a







correct age is essential. Every item of information should be carefully supplied. The cause of death clearly and briefly. Physicians: please write the causes of death clearly and briefly.

B-6 Dr Harding  
3805 Belair

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2777  
Registered No.

BIRTH NO. 50 2777

1. NAME OF DECEASED (Type or Print) <i>John C. Bredeknecht</i>			2. DATE OF DEATH <i>Mar. 22-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>3203 E Evergreen Ave</i> Yrs. <i>00</i> Mos. <i>00</i> Days <i>00</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-04 B</i>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>3203 E Evergreen Ave</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Aug 5-1868</i>		9. AGE (In years last birthday) <i>81</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B.O.R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>Bredeknecht</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Lump</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Florence Bredeknecht</i>	

18. <i>442X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Acute Cardiac Dilatation</i> DUE TO (B) <i>Ch. Myocarditis.</i> DUE TO (C) <i>Cardio-Vasc Renal Complex</i>	INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
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II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

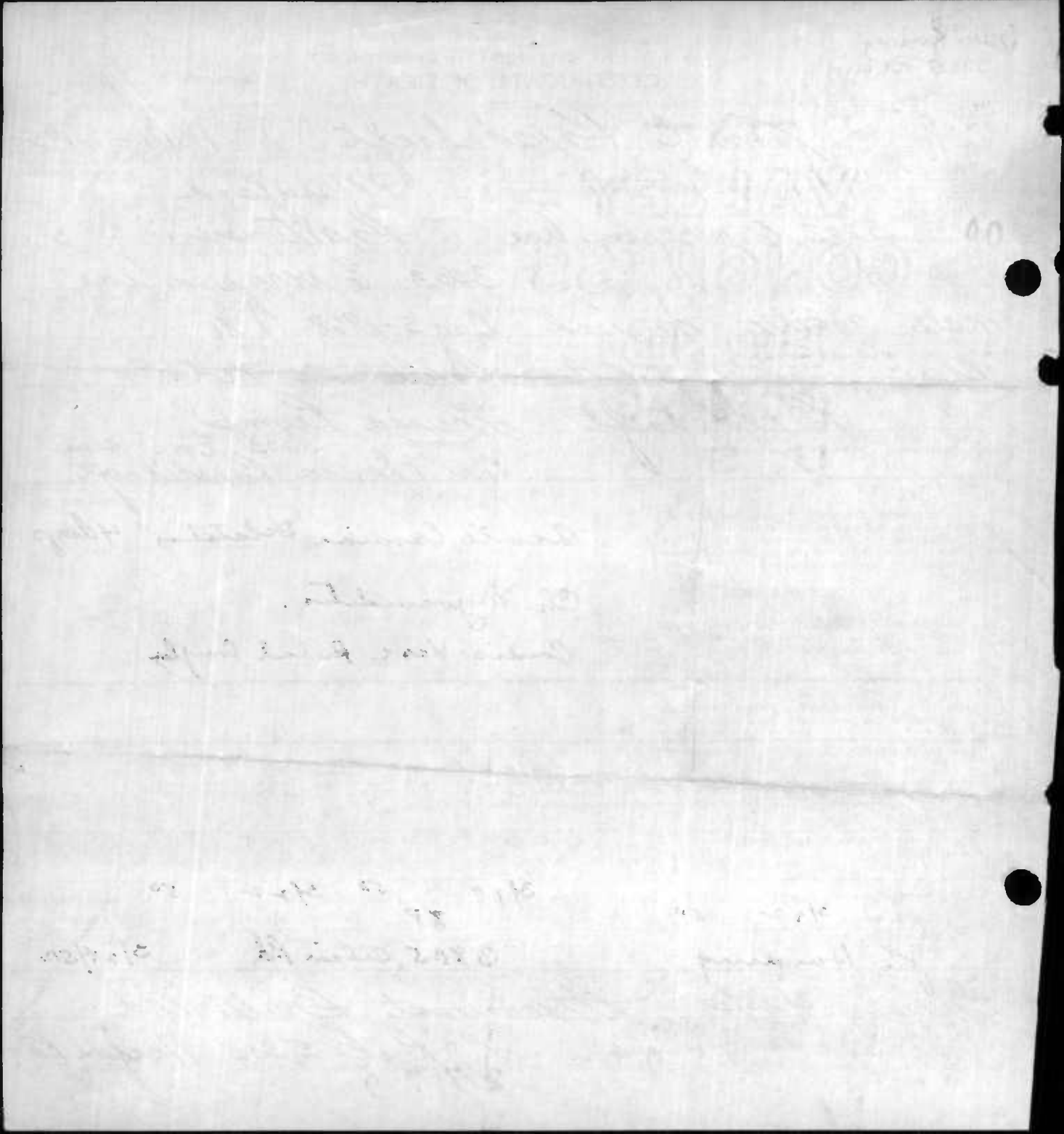
22. I hereby certify that I attended the deceased from *3/19*, 19*50*, to *3/22*, 19*50*, that I last saw the deceased alive on *3/22*, 19*50*, and that death occurred at *8 P* m., from the causes and on the date stated above.

23A. SIGNATURE <i>J S Harding</i>	23B. ADDRESS <i>3805 Belair Rd</i>	23C. DATE SIGNED <i>3/24/50</i>
--------------------------------------	---------------------------------------	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/25/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>	24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 25 1950</i>	REGISTRAR'S SIGNATURE <i>W. J. Halligan</i>	25. FUNERAL DIRECTOR <i>L. J. Luck</i>	ADDRESS <i>5305 Harford Rd</i>
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Correct age is especially important. Physicians: please write the causes of death clearly and briefly. Every item of information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2778  
Registered No. \_\_\_\_\_

50 2778 48-02280  
BIRTH NO. \_\_\_\_\_

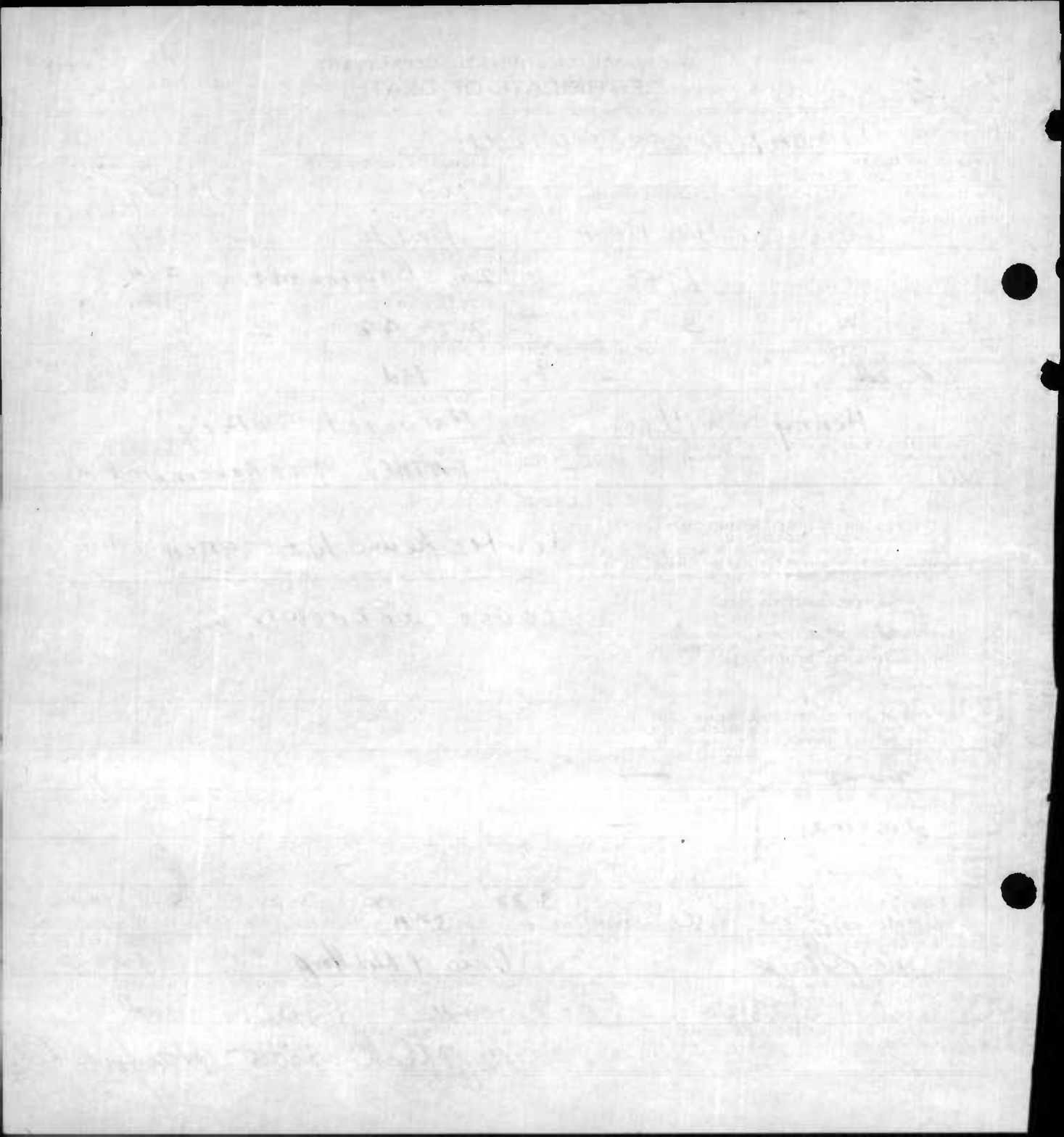
1. NAME OF DECEASED (Type or Print) <b>LINDA MARGARET WILLEM</b>		2. DATE OF DEATH <b>3-24-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MD Hosp</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. 27-07</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>2902 Bauernwood Ave, #14</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>2-2-48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <b>2</b>
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Henry B. Willem</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Slattery</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>FATHER</b>		ADDRESS <b>2902 Bauernwood Ave #14</b>	

18. <b>292.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>acute hemolytic anemia</b>	CAUSE OF DEATH (A) <b>acute hemolytic anemia</b> DUE TO (B) <b>cause unknown</b> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>disease</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____		
22. I hereby certify that I attended the deceased from <b>3-22</b> , 19 <b>50</b> , to <b>3-24</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-24</b> , 19 <b>50</b> , and that death occurred at <b>3:00 A. m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>Univ of Md Hosp</b>		23C. DATE SIGNED <b>3-24-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/21/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 25 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
FUNERAL DIRECTOR <b>L. J. Beck</b>		ADDRESS <b>5305 Hanford Rd</b>	







0161c



UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of funeral director

14. Signature of medical examiner

15. Signature of coroner

16. Signature of justice of the peace

17. Signature of health officer

18. Signature of local health department

19. Signature of state health department

20. Signature of federal health department

21. Signature of United States Department of Health and Human Services

22. Signature of President of the United States

23. Signature of Vice President of the United States

24. Signature of Speaker of the House of Representatives

25. Signature of President of the Senate

26. Signature of Chief Justice of the United States

27. Signature of Associate Justices of the United States

28. Signature of Federal Judges

29. Signature of State Judges

30. Signature of Local Judges

31. Signature of Justices of the Peace

32. Signature of Clergy

33. Signature of Ministers

34. Signature of Priests

35. Signature of Rabbis

36. Signature of Imams

37. Signature of Spiritual Leaders

38. Signature of Religious Leaders

39. Signature of Community Leaders

40. Signature of Public Officials

41. Signature of Members of Congress

42. Signature of Members of the Executive Branch

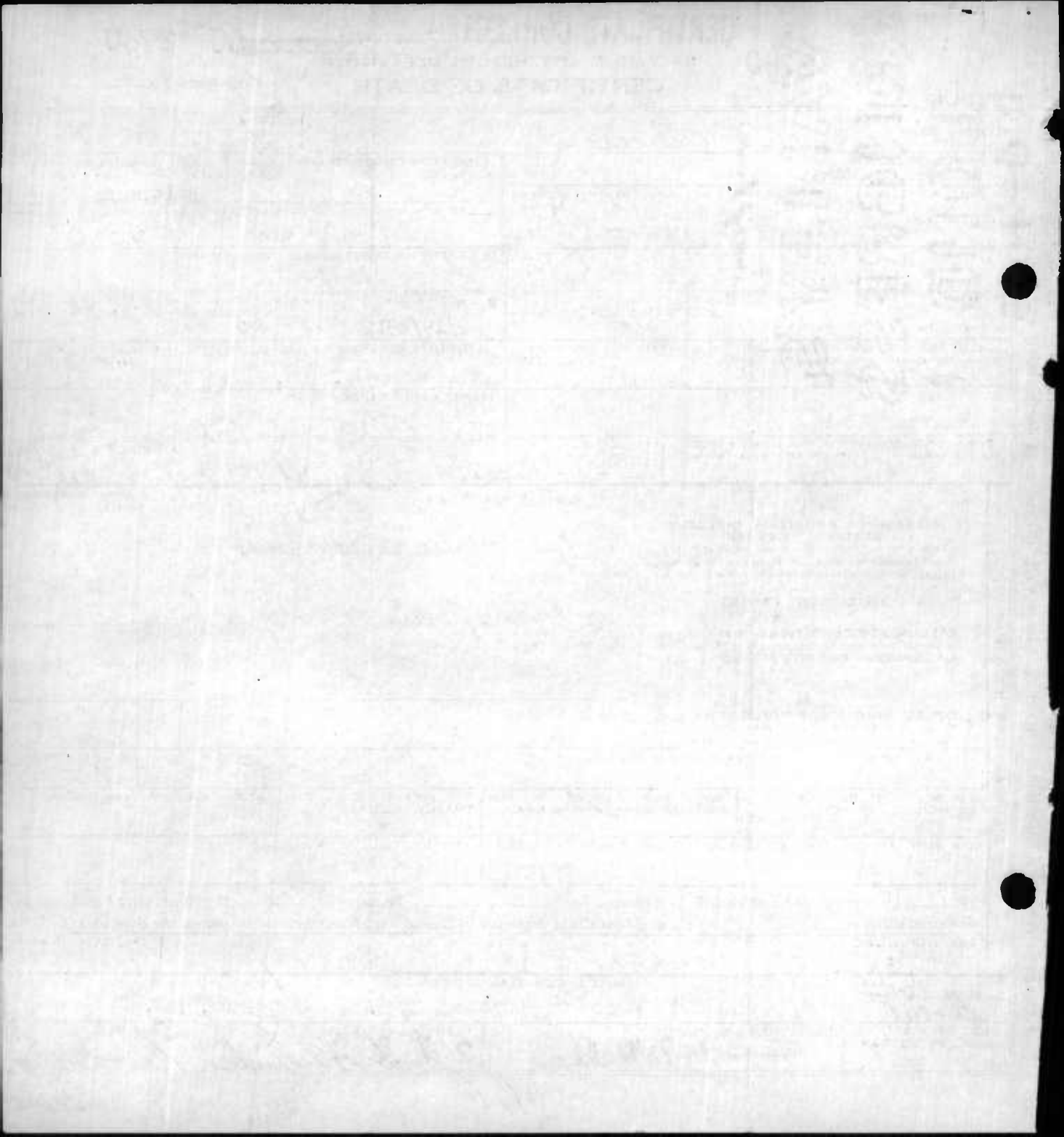
43. Signature of Members of the Judiciary

44. Signature of Members of the Military











Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

50 2781  
M-240

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mr. Robert Maxwell</b>		2. DATE OF DEATH <b>March 23, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>24-02</b>	
D. STREET ADDRESS (If rural, give location) <b>1327 Webster Street</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>4/6/1898</b>	
9. AGE (In years last birthday) <b>51</b>		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Boiler (M)</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James J. Jones</b>		ADDRESS	

18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Subarachnoid Hemorrhage</b> DUE TO <b>Chronic Hypertension</b> DUE TO <b>Chronic Gastritis</b> DUE TO <b>Ca, Cordis et Stomachi</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>3/14/50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Esophago-Gastrostomy. Resection of Carcinoma; Partial Gastrectomy;</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <b>March 3, 1950</b> , to <b>March 23, 1950</b> , that I last saw the deceased alive on <b>March 23, 1950</b> , and that death occurred at <b>10:20 P.M.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>James J. Jones</b>		23B. ADDRESS <b>1400 N. Caroline Street</b>	23C. DATE SIGNED <b>3/24/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>3-27-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Edgar Hill</b>	24D. LOCATION (City, town, or county) (State) <b>Bach.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 26 1950</b>	REGISTRAR'S SIGNATURE <b>William H. Jones</b>	25. FUNERAL DIRECTOR <b>James J. Jones</b>	

VS 150

30430 130 S. 1st St. - 46B







W-452  
50 2782BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2782  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EMILY WILLIAMS

2. DATE  
OF  
DEATH

Mar. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3468 Childs Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto.

D. STREET ADDRESS (If rural, give location)

3468 Childs Court

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

about 59

11. BIRTHPLACE (State or foreign country)

New Foundland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

ADDRESS

Mr. Thomas R. Williams 3468 Childs Court

18. 154X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Adeno-Carcinoma rectum

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Generalized Abdominal metastasis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1949 to Mar. 24, 1950, that I last saw the  
deceased alive on Mar. 24, 1950, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

James H. Ciarro

23B. ADDRESS

M. D.

1225 N. Calvert St.

23C. DATE SIGNED

3/25/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

Fairview Cem.

24D. LOCATION (City, town, or county) (State)

Catasauqua, Pa.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

J. J. TICKNER &amp; SONS

Balto., Md.



DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

NO. 100-10000

DATE OF DEATH

MA

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATIONAL HISTORY

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH



Physicians: please write the causes of death clearly and legibly. The cause of death is especially important.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Louise Krueger (GENERT)

2. DATE  
OF  
DEATH

3-24-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE MD. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore (Essex, Balto. Co.)

D. STREET ADDRESS (If rural, give location)  
714 Myrth Ave. Essex, Balto. Co. Z 21

Length of stay in Baltimore

12 years

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

13. FATHER'S NAME

? Kieffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

Mar. 24-1908

9. AGE (In years last birthday)

42 Yrs.

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

? ?

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Questionable Encephalitis DUE TO		
ANTECEDENT CAUSES (B) (over) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) Purulent bronchial plugs and atelectasis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
2				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-23-1950 to 3-24-1950 that I last saw the deceased alive on 3-24-1950 and that death occurred at 3:35 AM from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
<i>R. B. Rosen</i>	M. D. B. C. H. - 4940 Eastern Ave	3-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	Mar. 26-50	St. Mary's Cemu.	Elmhurst New York
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS	
MAR 26 1950	<i>Wm. J. O'Donnell</i>	<i>John J. O'Donnell</i> 411 Eastern Ave. Balto., Md. 8012	



See Document File 50-2783 for corrective authority

12/4/50

ES



B-530  
50 2784BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2784  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WOLF BENNETT

2. DATE  
OF  
DEATH

3/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

42 SINAI Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2602 E Baltimore St

Length of stay in Baltimore

65 yrs

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

1863

9. AGE (In years  
last birthday)

87

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

City Inspector

10B. KIND OF BUSINESS OR  
INDUSTRY

City of Balto

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Bennett

14. MOTHER'S MAIDEN NAME

Gussie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Morris Bennett 2602 E Baltimore St

18. 4/20/0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

(C)

Lobar pneumonia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/23, 1950 to 3/25, 1950, that I last saw the  
deceased alive on 3/25, 1950, and that death occurred at 6:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

March 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Friendship Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 1126

MAR 26 1950

257 Levington &amp; Bros

W North Ave



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



correct age is especially important. Physicians write the causes of death clearly and legibly. The attending physician's name and address must be written in the space provided.

L-150

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2785  
Registered No.

BIRTH NO. 50 2785

1. NAME OF DECEASED (Type or Print) <b>ELIAS LEVIN</b>		2. DATE OF DEATH <b>3/24/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Anwar</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-12</b>	
Length of stay in Baltimore <b>50</b> Yrs. <b>50</b> Mos. <b>50</b> Days		D. STREET ADDRESS (If rural, give location) <b>2908 Springhill Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-8-1880</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hotel Prop.</b>	9. AGE (In years last birthday) <b>70</b>
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Meyer Levin</b>		ADDRESS <b>5601 Key Ave</b>	

18. <b>470.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>AS40 - Failure</b>	CAUSE OF DEATH <b>Emphysema - Prob Or Pulmonary</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3/23**, 19**50**, to **3/24**, 19**50**, that I last saw the deceased alive on **3/24**, 19**50**, and that death occurred at **2 A** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Donald Kotz</b>	23B. ADDRESS <b>Genai Hosp</b>	23C. DATE SIGNED <b>3/24/50</b>
--------------------------------------	-----------------------------------	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-26-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Young Men</b>	24D. LOCATION (city, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>AP 26 1950</b>	REGISTRAR'S SIGNATURE <b>William H. Hargis</b>	25. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>	ADDRESS <b>2100 Eastern Pk</b>



\_\_\_\_\_



P. 250  
50 2786

50 2786

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 95411

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>IDA SARAH PACHINO</b>			2. DATE OF DEATH <b>March 24, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE <b>Md.</b> B. COUNTY (before admission)		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR <b>U. S. Marine Hospital</b> location) INSTITUTION <b>Wyman Pk. Drive &amp; 31st St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give <b>Baltimore</b> township) <b>15-04</b>		
Length of stay in Baltimore <b>Unkn. 49</b> Yrs. <del>Mon.</del> Days			D. STREET ADDRESS (If rural, give location) <b>1834 Walbrook Avenue</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7/25/98</b>		9. AGE (In years last birthday) <b>51</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None House wife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>
13. FATHER'S NAME <b>Louis Balser</b>			14. MOTHER'S MAIDEN NAME <b>Fannie Lipman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto., Md.</b>	

18. **175X** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.) (A) **Carcinoma right ovary with**  
DUE TO **generalized carcinomatosis** INTERVAL BETWEEN  
ONSET AND DEATH **Unkn**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> m. WORK AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan. 27**, 1950, to **Mar. 24**, 1950, that I last saw the  
deceased alive on **Mar. 24**, 1950, and that death occurred at **5 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>John L. Wilson, Medical Director</b>	23B. ADDRESS <b>U.S. Marine Hospital, Balto., Md.</b>	23C. DATE SIGNED <b>3-25-50</b>
---	--	------------------------------------

24A. BURIAL, CREMA- TION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>3-26-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
---	-----------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 26 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston</b>	25. FUNERAL DIRECTOR <b>JACK KEWIS JR</b>	ADDRESS <b>2100 Eutan Rd</b>
---	--	--	---------------------------------

49a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

REPORT OF THE UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
ON THE  
PLANT INDUSTRY OF THE  
UNITED STATES  
FOR THE YEAR 1907

By  
J. H. COOPER, Chief of Bureau  
and  
J. H. COOPER, Jr., Assistant Chief of Bureau

WASHINGTON  
GOVERNMENT PRINTING OFFICE  
1908



K-246  
50 2787

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2787  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Susan MYRTLE KESSLER</i>		2. DATE OF DEATH <i>3/25/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Ind</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>West Baltimore General Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore - 19-04</i>			
Length of stay in Baltimore <i>26 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>1840 W Pratt St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>4/25/1898</i>	9. AGE (In years last birthday) <i>51</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Penna</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles Cramer</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs Charles Bodnar Bennison 129 St.</i>	

18. <i>171 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION <i>0</i>		CAUSE OF DEATH (A) <i>Intestine Obstruction</i> (B) <i>Carcinoma Cervix</i> (C) <i>Adenoma thyroid, multiple</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i> <i>2 yrs.</i> <i>5 years</i>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED M. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/10/50</i> , 19 <i>50</i> , to <i>3/25</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/25</i> , 19 <i>50</i> , and that death occurred at <i>7:20 Am.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph Shear</i>		23B. ADDRESS <i>W.B.H.</i>		23C. DATE SIGNED <i>3-25-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/28/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>2930 Frederick Ave</i>		25. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son</i>		ADDRESS <i>48a St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>63 1950</i>		REGISTRAR'S SIGNATURE <i>John J. Cowan &amp; Son</i>		25. FUNERAL DIRECTOR ADDRESS <i>48a St.</i>	

MAR 29 1950

correct age is especially important. Physicians write the causes of death clearly and legibly.



1. *Journal of Management Studies*, 1996, 33, 1, 1-14.

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26



Z-400  
50 2788BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2788  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Olive M. Zill</i>		2. DATE OF DEATH <i>3/24/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Doctors Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>21-02</i>	
Length of stay in Baltimore <i>32 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>1206 Glyndon Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3/12/1888</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
13. FATHER'S NAME <i>Linwood Goslin</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mc Cree</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		17. INFORMANT <i>Philip J. Zill</i> ADDRESS <i>1206 Glyndon Ave</i>	
16. SOCIAL SECURITY NO. <i>-</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	

18. *443X* CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) *Acute Cardiac failure - Anasarca -*  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertensive Cardiac - Venous distension*  
DUE TOINTERVAL BETWEEN ONSET AND DEATH  
*5 days.**years.*II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Nov.*, 1949, to *MAR 23*, 1950, that I last saw the deceased alive on *MAR 23*, 1950, and that death occurred at *m.*, from the causes and on the date stated above.

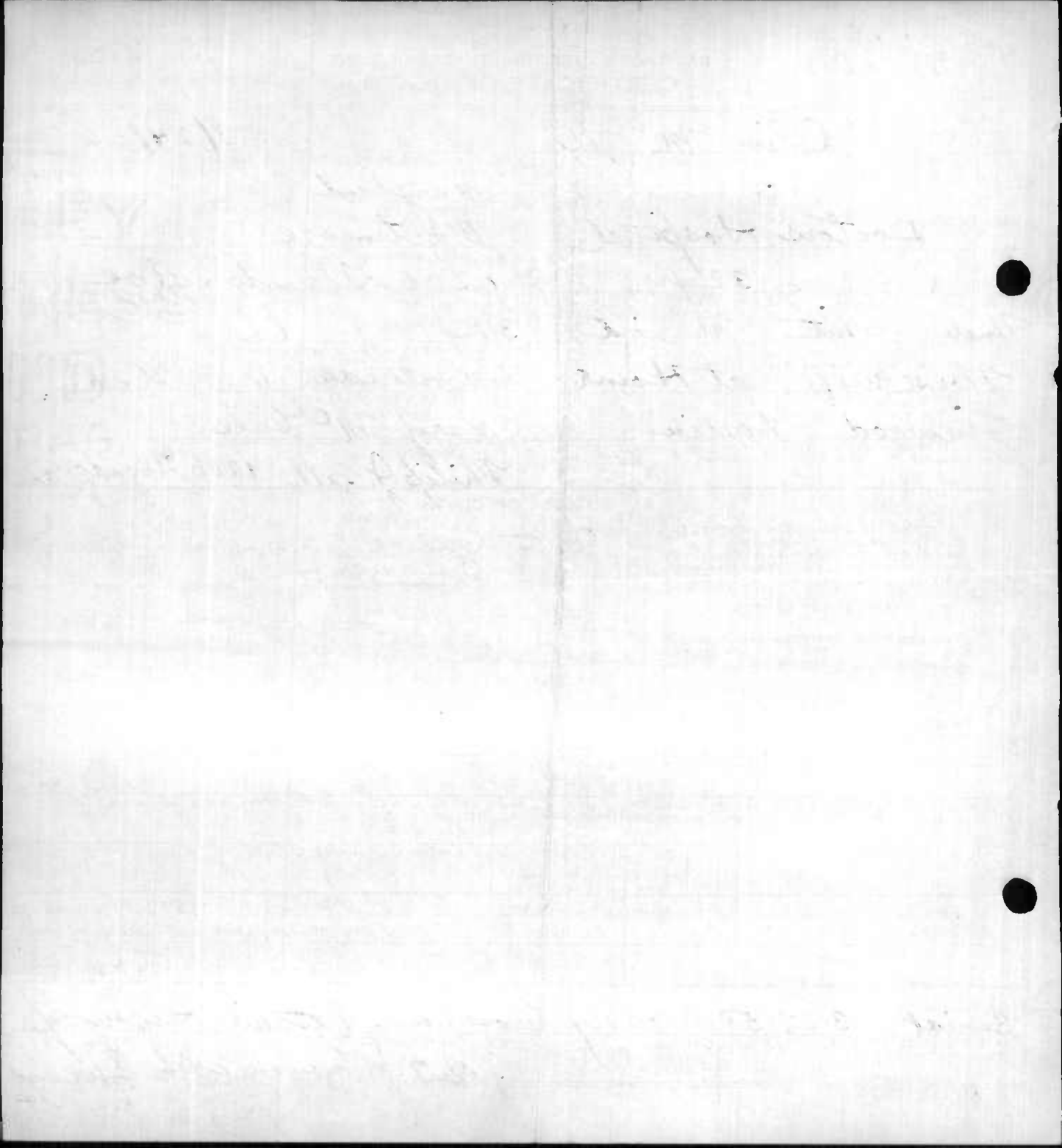
23A. SIGNATURE <i>Charles Tommasello</i> M. O.	23B. ADDRESS <i>900 W. Lombard St</i>	23C. DATE SIGNED <i>24 Mar. 1950</i>
--	--	---

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Pitche Highway</i>
---	--------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Christina Williams</i>	25. FUNERAL DIRECTOR <i>John J. Gowan &amp; Son</i>	ADDRESS <i>937 St</i>
----------------------------------	--	--	--------------------------

MAR 26 1950







2-522  
50 2789

LANCASTER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2789  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emma Lancaster

2. DATE  
OF  
DEATH

March 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Little Sisters of the Poor

Home for the Aged

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 10-01

D. STREET ADDRESS (If rural, give location)

1200 Valley St

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

Jan. 23, 1864

9. AGE (In years  
last birthday)

86

10. Under 1 Year  
Months

11. Under 24 Hours  
Days

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Grama

14. MOTHER'S MAIDEN NAME

Georgiana Poole

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT'S ADDRESS  
1200 Valley St.

18. 4221

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Edema Lungs

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Myocarditis

3 yrs

DUE TO

(C)

Arterio Sclerosis

10 yrs

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from March 1, 1950, to March 24, 1950, that I last saw the  
deceased alive on March 23, 1950, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

E. Gill Hall MD

23B. ADDRESS

16318 North Ave

23C. DATE SIGNED

March 24-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Mar 28/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William A. Williams

25. FUNERAL DIRECTOR

ADDRESS

Rita Wredefeld 900 E. Biddle St

MAR 26 1950

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.



*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

WALTON &  
BOND  
CO.



correct age is especially important. Physicians please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2790  
Registered No. \_\_\_\_\_

BIRTH NO. 50 2790

1. NAME OF DECEASED (Type or Print) <b>SAMUEL FONTE</b>			2. DATE OF DEATH <b>Mar. 23, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>4015 Elderon Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>4015 Elderon Ave.</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Aug. 8, 1882</b>	9. AGE (In years, last birthday) <b>67</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Counter Clerk &amp; Cook</b>			11. BIRTHPLACE (State or foreign country) <b>Italy</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>			12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		
13. FATHER'S NAME <b>Francisco Fonte</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <b>Mrs. Virginia S. Levy</b>			ADDRESS <b>4015 Elderon Ave.</b>		

18. <b>162x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Carcinomatosis</b> DUE TO <b>Adeno Carcinoma - Bronchogenic</b> DUE TO <b>1 1/2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/22</b> , 19 <b>50</b> , to <b>3/23</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3/23</b> , 19 <b>50</b> , and that death occurred at <b>2:30 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>R. Kleiman</b>		23B. ADDRESS <b>3903 Edmond Ln Ave -</b>		23C. DATE SIGNED <b>3/25/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/27/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Wm. J. Ticker</b>		25. FUNERAL DIRECTOR <b>Wm. J. Ticker &amp; Sons</b>	
				ADDRESS <b>Balto., Md.</b>	

MAR 25 1950

78071

47c



DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

REPORT OF INVESTIGATION

U. S. A.

100% RAB

BOND

CONCRETE

WATER

100% RAB

100% RAB

100% RAB

100% RAB



PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2791  
Registered No. 50 2791

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Karl Hansen

2. DATE  
OF  
DEATH

3-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hospital

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 7 1892

9. AGE (In years  
last birthday)

58 yrs.

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SEAMAN

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Latvia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Hanson

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 442X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Terminal Uremia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cardiac renal disease  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized arteriosclerosis  
Bronchopneumonia - rt. base  
Chronic Alveolitis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 3/20/50, 19, to 3/22/50, 19, that I last saw the  
deceased alive on 3/22/50, 19, and that death occurred at 10:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

George Plut

M. D.

23B. ADDRESS

So. Balto. General Hosp.

23C. DATE SIGNED

3-23-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Chas. F. Hill 1501 E. Fort Ave.

VS 150

MAR 25 1950

46051

131a



RECEIVED  
OFFICE OF THE  
CHIEF MEDICAL EXAMINER

RECEIVED

MAR 25 1950

Chief Medical Examiner's Office



correct age is especially important. Physicians write the causes of death clearly and legibly.

8-652 50 2792

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2792

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

HELENA BEHRINGER

2. DATE  
OF  
DEATH

March 25, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3410 Harmony Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

26-09

D. STREET ADDRESS (If rural, give location)

3410 Harmony Court

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

June 27 1891

9. AGE (In years  
last birthday)

58

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House Work

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH D. LAMMERS

14. MOTHER'S MAIDEN NAME

JEANETTE MAINIUS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Anna Neimiller 830 S. Conkling St.

18. 592X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Acute Pulmonary Edema

38 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Myocarditis

Chronic Ischemic Heart Disease

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 1949 to 1950, that I last saw the  
deceased alive on 3/24/50, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

March 27 1950

Sacred Heart Cemetery

4703 German Hill Rd. Balto Co.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Wilmington, Delaware

Charles S. Seiler 901 S. Conkling St.



REPORT OF THE BOARD OF DIRECTORS  
FOR THE YEAR 1900

THE BOARD OF DIRECTORS  
OF THE  
UNITED STATES  
NAVY  
HAS THE HONOR TO  
REPORT TO THE  
HOUSE OF REPRESENTATIVES  
THE RESULTS OF THE  
OPERATIONS OF THE  
NAVY DURING THE  
YEAR 1900.

THE BOARD OF DIRECTORS  
OF THE  
UNITED STATES  
NAVY  
HAS THE HONOR TO  
REPORT TO THE  
HOUSE OF REPRESENTATIVES  
THE RESULTS OF THE  
OPERATIONS OF THE  
NAVY DURING THE  
YEAR 1900.

THE BOARD OF DIRECTORS  
OF THE  
UNITED STATES  
NAVY  
HAS THE HONOR TO  
REPORT TO THE  
HOUSE OF REPRESENTATIVES  
THE RESULTS OF THE  
OPERATIONS OF THE  
NAVY DURING THE  
YEAR 1900.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

534  
50 2793

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2793  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank Martin Chandler

2. DATE  
OF  
DEATH

3-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

since 1938

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan 2, 1891

9. AGE (In years  
last birthday)

59 58

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

General Insurance

10b. KIND OF BUSINESS OR  
INDUSTRY

Insurance

11. BIRTHPLACE (State or foreign country)

New Haven Conn

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John C. Chandler

14. MOTHER'S MAIDEN NAME

Elvena Klorica

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Wife

ADDRESS

Same

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Acute Coronary Thrombosis Sudden

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Hypertension Disease

Unknown

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1945, to 3-24-50, that I last saw the deceased alive on 3/24-50, and that death occurred at 8:50 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Huntington Hill Cemetery

12745 Coul



STATEMENT OF DEATH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of military		26. Signature of police		27. Signature of fire		28. Signature of health	
29. Signature of education		30. Signature of culture		31. Signature of religion		32. Signature of society	
33. Signature of family		34. Signature of friends		35. Signature of neighbors		36. Signature of community	
37. Signature of school		38. Signature of employer		39. Signature of business		40. Signature of government	
41. Signature of military		42. Signature of police		43. Signature of fire		44. Signature of health	
45. Signature of education		46. Signature of culture		47. Signature of religion		48. Signature of society	
49. Signature of family		50. Signature of friends		51. Signature of neighbors		52. Signature of community	
53. Signature of school		54. Signature of employer		55. Signature of business		56. Signature of government	
57. Signature of military		58. Signature of police		59. Signature of fire		60. Signature of health	
61. Signature of education		62. Signature of culture		63. Signature of religion		64. Signature of society	
65. Signature of family		66. Signature of friends		67. Signature of neighbors		68. Signature of community	
69. Signature of school		70. Signature of employer		71. Signature of business		72. Signature of government	
73. Signature of military		74. Signature of police		75. Signature of fire		76. Signature of health	
77. Signature of education		78. Signature of culture		79. Signature of religion		80. Signature of society	
81. Signature of family		82. Signature of friends		83. Signature of neighbors		84. Signature of community	
85. Signature of school		86. Signature of employer		87. Signature of business		88. Signature of government	
89. Signature of military		90. Signature of police		91. Signature of fire		92. Signature of health	
93. Signature of education		94. Signature of culture		95. Signature of religion		96. Signature of society	
97. Signature of family		98. Signature of friends		99. Signature of neighbors		100. Signature of community	



W-450  
50 2794

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2794  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BRIDGET WHALEN

2. DATE  
OF  
DEATH

March 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5150 Old Frederick Road.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

420 W. 23rd Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 10, 1864

9. AGE (In years  
last birthday)

85

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Whalen

14. MOTHER'S MAIDEN NAME

Margaret, (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS  
Samuel Miller, 5150 Old Frederick Road.

18. 191 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CARCINOMA FACE & NOSE

6 MONTHS

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

SENILITY

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOV, 19 49, March, 25, 19 50 that I last saw the  
deceased alive on March 19 50 and that death occurred at 6:30 AM from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/25/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county)  
(State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

Huntington McPaul, M.D.

25. FUNERAL DIRECTOR

William Cook, Inc., 1217 St. Paul St.

ADDRESS

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

-645 50 2795				DARLING BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				50 2795 Registered No. 3-32255			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>DEWAYNE LeROY DARLING</b>				2. DATE OF DEATH <b>MAR 25 1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Mich.</b> B. COUNTY <b>V-19</b>							
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Sunfield</b>							
Length of stay in Baltimore <b>9 days</b>				D. STREET ADDRESS (If rural, give location)							
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>		8. DATE OF BIRTH <b>9-26-47</b>		9. AGE (In years last birthday) <b>2</b>		10. Under 1 Year Months: <b>5</b> Days: <b>5</b> Hours: <b>5</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Michigan</b>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Le Roy Darling</b>				14. MOTHER'S MAIDEN NAME <b>Alma Hayes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.				17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b> ADDRESS			
18. <b>754.6</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Transposition of Great Vessels congenital</b> DUE TO <b>(B) Cerebral anoxia</b> DUE TO <b>(C)</b> INTERVAL BETWEEN ONSET AND DEATH <b>60 hrs.</b>											
MEDICAL CERTIFICATION II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>3/23/50</b>				19B. MAJOR FINDINGS OF OPERATION <b>Transposition of Great Vessels</b>				20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)				21B. PLACE OF INJURY (e. g., about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3-21-</b> , 19 <b>50</b> to <b>3-25-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-25-</b> , 19 <b>50</b> , and that death occurred at <b>12 M.N.</b> , from the causes and on the date stated above.											
23A. SIGNATURE <b>Richard A. Kipper, Jr. M.D.</b>				23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				23C. DATE SIGNED <b>3/26/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				24B. DATE <b>3/27/50</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Sunfield Michigan</b>			
24D. LOCATION (City, town, or county) (State) <b>2024</b>				25. FUNERAL DIRECTOR <b>Philip Herwig Sons Orleans</b>							
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>				REGISTRAR'S SIGNATURE <b>Amington Williams, M.D.</b>							



CERTIFICATE OF DEATH

John A. Smith

Age 65

Male

White

Married

Single

Widowed

Divorced

Never married

Married

Single

Widowed

Divorced

Never married

Married

Single

Widowed

Divorced

Never married

Married

Single

Widowed

Divorced

Never married

Married

Single

Widowed

Divorced

Never married



PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

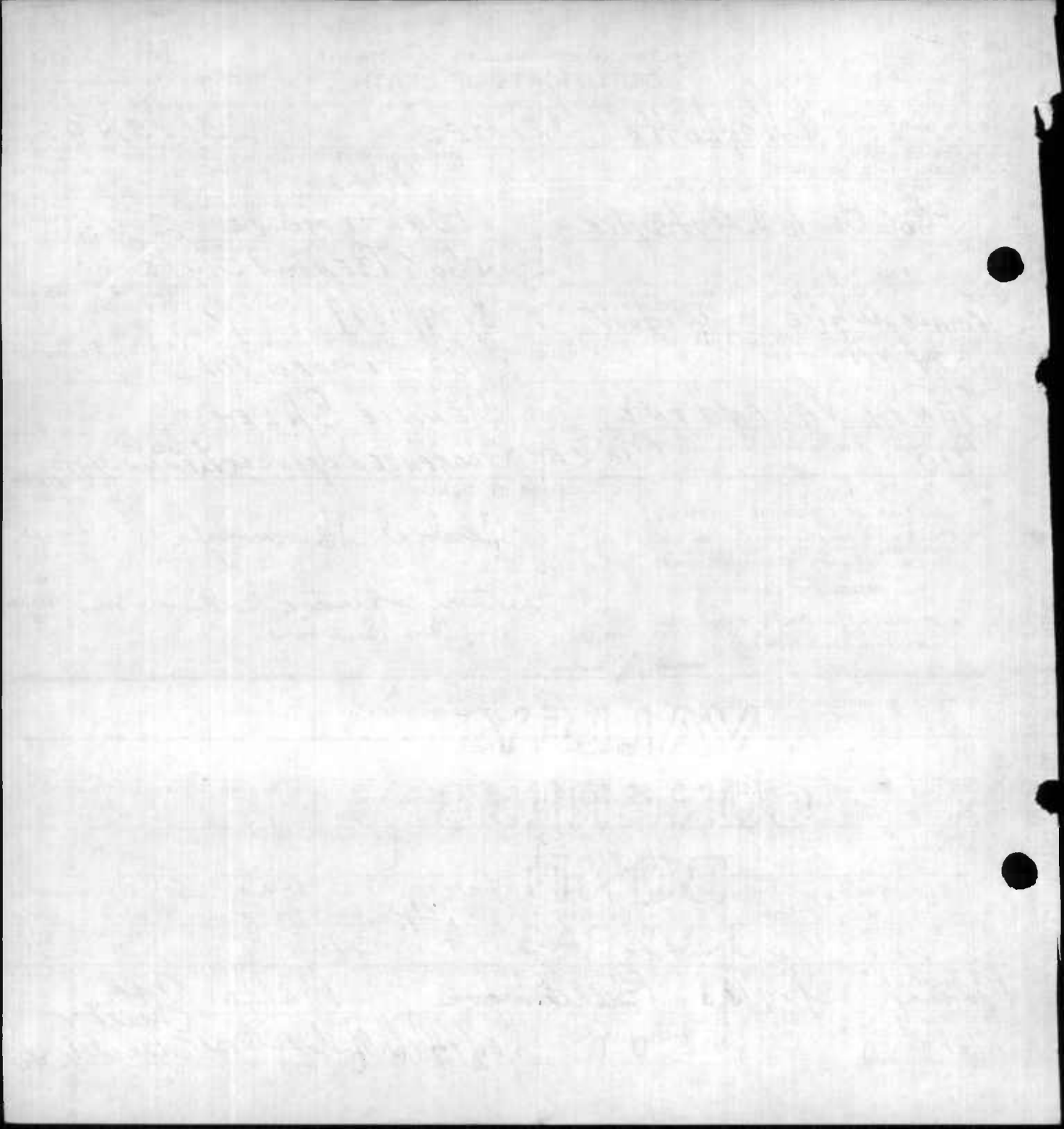
652  
50 2796

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2796  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Charlotte Grimes		3/23/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 5606 BENTON HTS AVE		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-04A			
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 5606 BENTON HTS			
5. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 8/29/1879		9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
13. FATHER'S NAME HENRY VALENTINE		14. MOTHER'S MAIDEN NAME JENNIE GALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT DORCEA SPENCER BENTON HTS AVE	
18. 422.1		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Hemorrhage			5 days
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardiovascular Disease			many yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1948, to 3-23, 1950, that I last saw the deceased alive on 3-22, 1950, and that death occurred at 9:21 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Max R English		23B. ADDRESS 5713 Belair Rd		23C. DATE SIGNED 3-24-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 3/27/50	24C. NAME OF CEMETERY OR CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR MAR 27 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR J. H. Walters	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2797

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

SPACE SHOWACRE

2. DATE  
OF  
DEATH

3/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1737 W. Lombard St

C. Length of stay in Baltimore  
Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

Md

B. COUNTY

18-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1737 W. Lombard St

8. DATE OF BIRTH

1/11/1881

9. AGE (in years last birthday)

69

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md

12. CITIZEN OF  
WHAT COUNTRY?

13. MOTHER'S MAIDEN NAME

ISABELLE WARD

13. FATHER'S NAME

MASTEN BRUNDIGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

BARL J. SHOWACRE 1737 W. Lombard St

18. 731X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchial Pneumonia

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Paget's Disease (OSTEITIS Deformans)

6 Months

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1949 to March 24, 1950, that I last saw the  
deceased alive on March 24, 1950 and that death occurred at 6:39 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Alfred Cole

M. D.

23B. ADDRESS

1934 Wilkens Ave

23C. DATE SIGNED

3-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/28/50

24C. NAME OF CEMETERY OR CREMATORY

Glenn Haven

24D. LOCATION (City, town, or county)

A. A. Co. Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. H. H. H. H.

25. FUNERAL DIRECTOR

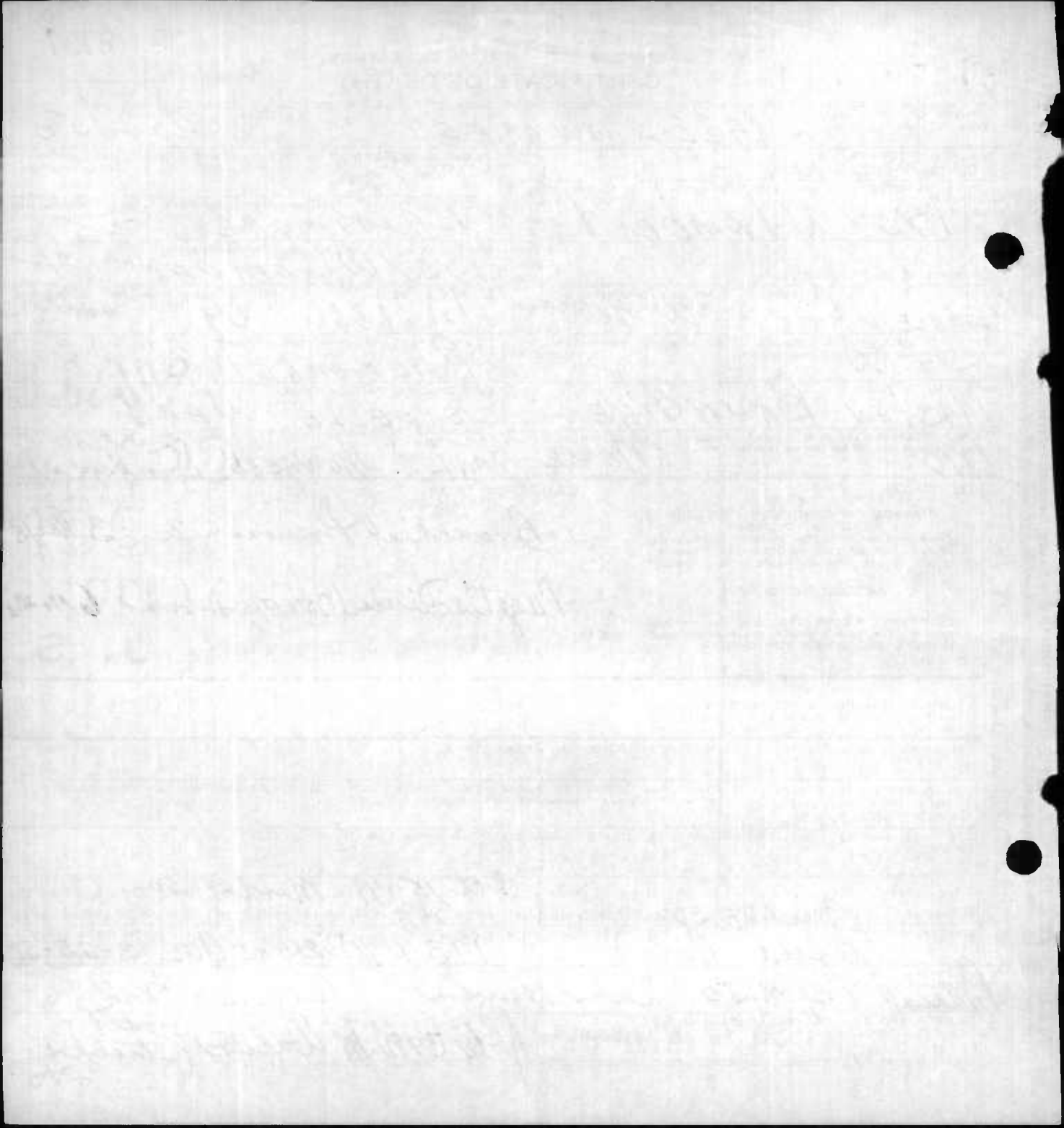
Wm. H. H. H. H.

Wm. H. H. H. H.

VS 150

107







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

425  
50 2798  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Sarah M. Lallaghan</i>		2. DATE OF DEATH <i>Mar 25<sup>th</sup> 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>424 Freeman St</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>25-04</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i>	
6. Length of stay in Baltimore <i>25</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>424 Freeman St</i>	
7. SEX <i>Female</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	10. DATE OF BIRTH <i>Oct 10<sup>th</sup> 1892</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. AGE (In years last birthday) <i>77</i>
12. FATHER'S NAME <i>Jacob Elmore</i>		13. BIRTHPLACE (State or foreign country) <i>Va.</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)		15. SOCIAL SECURITY NO.	
16. MOTHER'S MAIDEN NAME <i>-</i>		17. INFORMANT <i>Mrs Ruth Lallaghan</i>	
18. ADDRESS <i>424 Freeman St</i>		19. ADDRESS <i>424 Freeman St</i>	

18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Instantaneous</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Chronic arteriosclerotic Hardening of arteries</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>3-25, 1950</i> to <i>3-25, 1950</i> that I last saw the deceased alive on <i>3-25, 1950</i> and that death occurred at <i>4 P</i> m., from the causes and on the date stated above.				
23A. SIGNATURE <i>Norman Linberg M.D.</i>		23B. ADDRESS <i>320 Potomac Ave</i>		23C. DATE SIGNED <i>3-25-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Mar 26 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Sunrise Cem</i>	24D. LOCATION (City, town, or county) (State) <i>Blifton George Va</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		
25. FUNERAL DIRECTOR <i>Leo B. Brooks</i>		ADDRESS <i>103 N. Patt Ph Ave</i>		



1944  
77  
72

Alga 3643



PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-500

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2799

Registered No. \_\_\_\_\_

50 2799  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Glenn Sim</i>		2. DATE OF DEATH <i>March 24/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>3520 N. Hilton Rd.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>Ind</i> COUNTY <i>Balto</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Shriners Nursing Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 28-01</i>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS, (If rural, give location) <i>5406 Reisterstown Road</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Jan 21, 1870</i>
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Retired Accountant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. U. S. Government</i>	9. AGE (In years last birthday) <i>80</i>
11. BIRTHPLACE (State or foreign country) <i>Balto. Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Robert Sim</i>		14. MOTHER'S MAIDEN NAME <i>Martha Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Miss Helen Hook</i>		ADDRESS <i>5406 Reisterstown Rd.</i>	

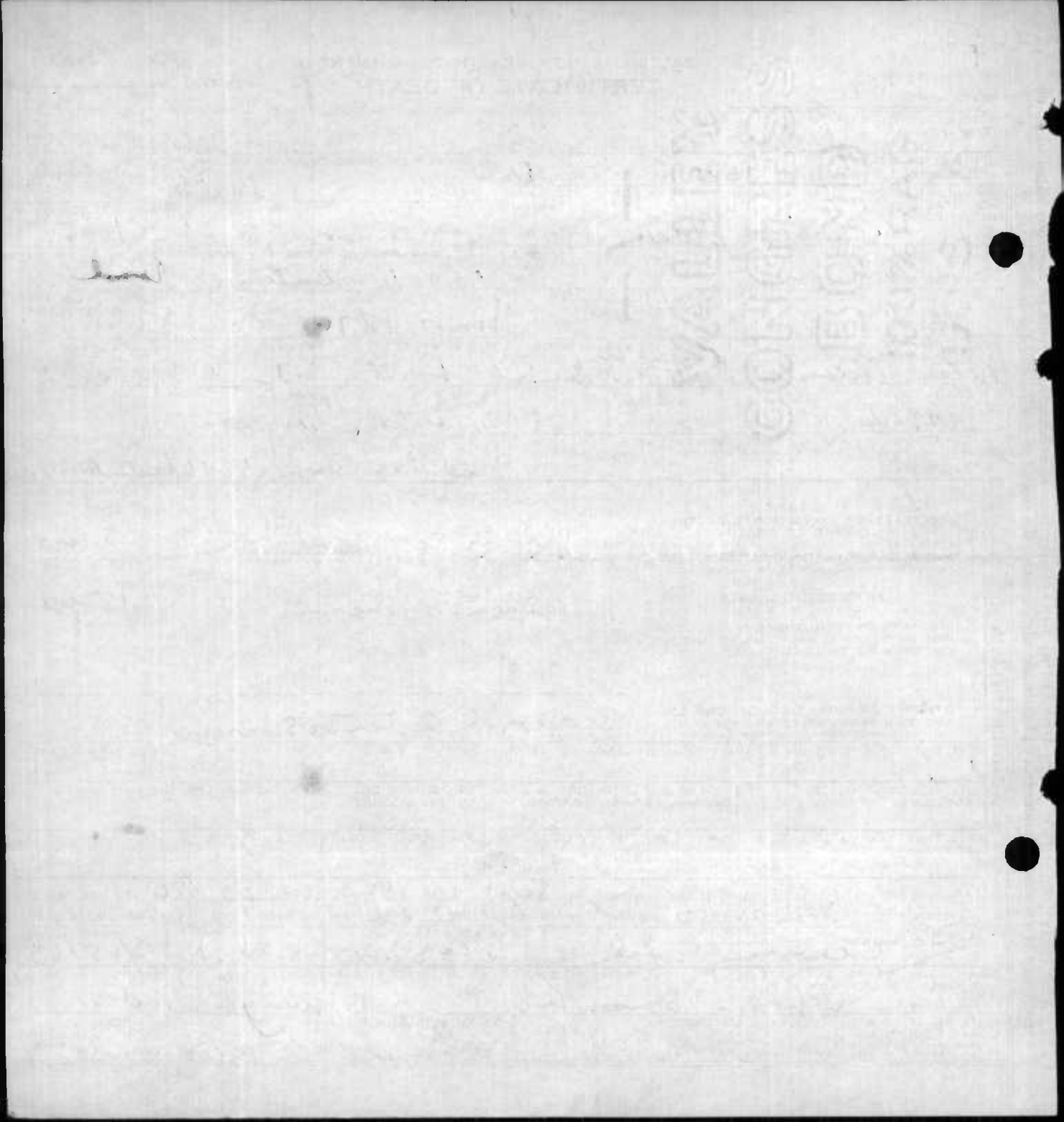
MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>arteriosclerosis</i>		<i>15 yrs</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cerebral Arteriosclerosis</i>		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? in Baltimore City, give exact location	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sept 15, 1944</i> to <i>Mar 23, 1950</i> that I last saw the deceased alive on <i>Mar 23, 1950</i> and that death occurred at <i>4:30 p. m.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>John E. Del</i>		23B. ADDRESS <i>3403 Jarvis Blvd</i>		23C. DATE SIGNED <i>3/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Feb 27/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Ind.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>		24F. REGISTRAR'S SIGNATURE <i>William C. ...</i>	
24G. FUNERAL DIRECTOR <i>Spring Byers</i>		24H. ADDRESS <i>5005 Ph ...</i>			

93D







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-146

Kibler

50 2800

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2800

Registered No.

BIRTH NO. 50-05102

1. NAME OF DECEASED (Type or Print) <i>Linda Kibler</i>			2. DATE OF DEATH <i>3/26/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore Yrs. Mos. Days <i>3648</i>			D. STREET ADDRESS (If rural, give location) <i>Washington Blvd.</i>		
6. SEX <i>F</i>	7. COLOR OR RACE <i>W</i>	8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	9. DATE OF BIRTH <i>3-13-50</i>		10. AGE (In years last birthday) Months: Days: Min. <i>18</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Luke Kibler</i>			14. MOTHER'S MAIDEN NAME <i>Lorena</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Luke Kibler</i> ADDRESS <i>3648 Washington Blvd.</i>		

MEDICAL CERTIFICATION

18. <i>76201</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.	CAUSE OF DEATH (A) <i>ATELECTASIS</i> DUE TO (B) <i>TERMINAL PNEUMONIA</i> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION <i>3/25/50</i>	19B. MAJOR FINDINGS OF OPERATION <i>TRACHEOTOMY - SLIGHT EDEMA</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>3/23</i> , 19 <i>50</i> to <i>3/26</i> , 19 <i>50</i> that I last saw the deceased alive on <i>3/26</i> , 19 <i>50</i> and that death occurred at <i>2:05</i> p. m., from the causes and on the date stated above.		
23A. SIGNATURE <i>Charles H. Shaw</i> M. O.	23B. ADDRESS <i>St. Agnes Hosp.</i>	23C. DATE SIGNED <i>3/26/50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>March 27</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	24D. LOCATION (City, town, or county) (State) <i>Towson MD</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Williams</i>	25. FUNERAL DIRECTOR <i>50-12-34</i>	ADDRESS <i>Baltimore Md.</i>



RECEIVED OF THE

James P. Allen

Mrs. J. P. Allen

21 April 1924

1000

1000

James P. Allen

James P. Allen

James P. Allen

James P. Allen

James P. Allen

James P. Allen

James P. Allen



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians write the causes of death clearly and legibly.

B-626  
50 2801  
BIRTH NO.

BRASHEARS  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2801  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Mr. MORGAN BRASHEARS.</b>		2. DATE OF DEATH <b>3. 26. 50.</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <input checked="" type="checkbox"/>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland.</b> B. COUNTY <b>Carroll</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Mount Airy. Rural.</b>	
c. Length of stay in Baltimore <b>11 1/2 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>Mt. Airy.</b>	
5. SEX <b>Male.</b>	6. COLOR OR RACE <b>White.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed.</b>	8. DATE OF BIRTH <b>1.10.1867.</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. Under 1 Year Months: Days: Hours: Min.	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Mount Airy.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zachariah Brashears.</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harshen.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <b>450.1</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Heart failure.</b>		
ANTECEDENT CAUSES		(B) <b>Generalized arteriosclerosis.</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <b>Gangrene left leg.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>1.3.50, 1.23.50.</b>		19B. MAJOR FINDINGS OF OPERATION <b>Gangrene left leg.</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>12.17.</b> , 19 <b>49</b> to <b>3.26.</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3.26.</b> , 19 <b>50</b> , and that death occurred at <b>1.20 p.m.</b> , from the causes and on the date stated above.				
22A. SIGNATURE <b>Wayne N. Jacobs, M.D.</b>		22B. ADDRESS <b>M. D. Church Home &amp; Hosp.</b>		22C. DATE SIGNED <b>3.26.50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/29/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Prospect Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Mt Airy Carroll Co. Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, Jr.</b>	25. FUNERAL DIRECTOR <b>C. M. Wally Winfield, Md.</b>		



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

Patent Office, Washington, D. C.  
May 10, 1906

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 4th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,

Wm. B. Harkness

Director

Bureau of Plant Industry

Washington, D. C.

Enclosed for you are two copies of the report of the

Committee on the proposed new classification of the

plants of the United States.

I am, Sir, very respectfully,  
Yours very truly,

Wm. B. Harkness

Director

Bureau of Plant Industry

Washington, D. C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

200  
50 2802

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 2802  
Registered No.

BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <b>FRANK H. ZOUCK</b>		
2. DATE OF DEATH <b>3-26-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>		
6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>REISTERSTOWN</b>		
7. STREET ADDRESS (If rural, give location)		
c. Length of stay in Baltimore Yrs. Mos. Days		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>
8. DATE OF BIRTH <b>JUNE 13, 1865</b>		9. AGE (In years last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>HENRY ZOUCK</b>		14. MOTHER'S MAIDEN NAME <b>MARY FOWBLE</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.
17. INFORMANT <b>PATIENT</b>		ADDRESS

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO <b>CORONARY OCCLUSION</b> <del>ARTERIO-SCLEROTIC HEART DISEASE</del>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO <b>ARTERIO-SCLEROTIC HEART DISEASE</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>GASTROINTESTINAL HEMORRHAGE</b>		
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3-25</b> , 19 <b>50</b> , to <b>3-26</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-26</b> , 19 <b>50</b> , and that death occurred at <b>4 P. M.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>Henry Charlton Leo Loeffel</b>	23B. ADDRESS <b>Union Memorial Hospital</b>	23C. DATE SIGNED <b>3-26-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>Mar. 29-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St Paul Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Hyattsville, Md</b>	25. FUNERAL DIRECTOR <b>John P. Clark</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. H. Williams, Jr.</b>	ADDRESS <b>Sons Reisterstown Md</b>

93D



DEATH CERTIFICATE

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of birth		6. Occupation		7. Cause of death		8. Signature of physician	
9. Name of informant		10. Address of informant		11. Date of completion		12. Signature of registrar	
13. Name of funeral home		14. Address of funeral home		15. Date of interment		16. Signature of funeral home	
17. Name of cemetery		18. Address of cemetery		19. Date of burial		20. Signature of cemetery	
21. Name of next of kin		22. Address of next of kin		23. Date of completion		24. Signature of next of kin	
25. Name of physician		26. Address of physician		27. Date of completion		28. Signature of physician	
29. Name of registrar		30. Address of registrar		31. Date of completion		32. Signature of registrar	
33. Name of funeral home		34. Address of funeral home		35. Date of completion		36. Signature of funeral home	
37. Name of cemetery		38. Address of cemetery		39. Date of completion		40. Signature of cemetery	
41. Name of next of kin		42. Address of next of kin		43. Date of completion		44. Signature of next of kin	
45. Name of physician		46. Address of physician		47. Date of completion		48. Signature of physician	
49. Name of registrar		50. Address of registrar		51. Date of completion		52. Signature of registrar	
53. Name of funeral home		54. Address of funeral home		55. Date of completion		56. Signature of funeral home	
57. Name of cemetery		58. Address of cemetery		59. Date of completion		60. Signature of cemetery	
61. Name of next of kin		62. Address of next of kin		63. Date of completion		64. Signature of next of kin	
65. Name of physician		66. Address of physician		67. Date of completion		68. Signature of physician	
69. Name of registrar		70. Address of registrar		71. Date of completion		72. Signature of registrar	
73. Name of funeral home		74. Address of funeral home		75. Date of completion		76. Signature of funeral home	
77. Name of cemetery		78. Address of cemetery		79. Date of completion		80. Signature of cemetery	
81. Name of next of kin		82. Address of next of kin		83. Date of completion		84. Signature of next of kin	
85. Name of physician		86. Address of physician		87. Date of completion		88. Signature of physician	
89. Name of registrar		90. Address of registrar		91. Date of completion		92. Signature of registrar	
93. Name of funeral home		94. Address of funeral home		95. Date of completion		96. Signature of funeral home	
97. Name of cemetery		98. Address of cemetery		99. Date of completion		100. Signature of cemetery	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-141

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2803

BIRTH NO. 50 2803

1. NAME OF DECEASED (Type or Print) <i>Josephine Appleby</i>			2. DATE OF DEATH <i>March 24, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 26-04A</i>		
c. Length of stay in Baltimore <i>Residing 3/</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>917 Harnem Lane</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>3-19-19</i>	9. AGE (In years last birthday) <i>31</i>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>			11. BIRTHPLACE (State or foreign country) <i>BALTIMORE M/D</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>GEORGE J. SANTAS</i>			14. MOTHER'S MAIDEN NAME <i>ALICE J. YANAVICH</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>none</i>		
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>			ADDRESS		

MEDICAL CERTIFICATION	18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Uremia + Congestive failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <i>Hypertensive CVD.</i> <i>10 yrs.</i>	
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <i>Rheumatic N-D - a bacterial mening.</i>	
	19A. DATE OF OPERATION <i>2-16</i>	19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>2-16</i> , 1950, to <i>3-24</i> , 1950, that I last saw the deceased alive on <i>3-24</i> , 1950, and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Evan Lukins</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>3-24-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>
24D. LOCATION (City, town, or county) (State) <i>Beltz Road</i>		25. FUNERAL DIRECTOR <i>Charles W. Peterson</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>		ADDRESS <i>703 4th Ave N. H.</i>



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1900

1900



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2804  
Registered No. \_\_\_\_\_

50 2804  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mr. William George Demmler</b>		2. DATE OF DEATH <b>March 25, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>121 Linhigh Avenue</b>			
c. Length of stay in Baltimore <b>11yr.</b>		Yrs. Mos. Days	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 26th, 1913</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>G. L. Martin Co.</b>	
13. FATHER'S NAME <b>Fredk. A. Demmler</b>		14. MOTHER'S MAIDEN NAME <b>Lyda Colgan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>177-03-8410</b>	
17. INFORMANT <b>Mrs. W.G. Demmler</b>		ADDRESS <b>121 Linhigh Ave. Balto. 6, Md</b>	

<p>18. <b>196x</b></p> <p><b>CAUSE OF DEATH</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>(A) <b>Metastatic carcinoma</b></p> <p>DUE TO <b>chondrosarcoma of right femur</b></p> <p>(B) _____</p> <p>DUE TO _____</p> <p>(C) <b>Primary site, right thigh</b></p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>over</b></p>

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2/24/</b> , 19 <b>50</b> to <b>3/25/</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3/25/</b> , 19 <b>50</b> , and that death occurred at <b>5:10AM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Thaddeus Swinski</b>		23B. ADDRESS <b>1100 N. Caroline Street</b>		23C. DATE SIGNED <b>3/25/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>Mar. 27, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Thaddeus Swinski</b>	
24G. ADDRESS <b>7401 Belair Rd.</b>		24H. FUNERAL DIRECTOR <b>Lassalmer Funeral Home</b>		24I. ADDRESS <b>7401 Belair Rd.</b>	



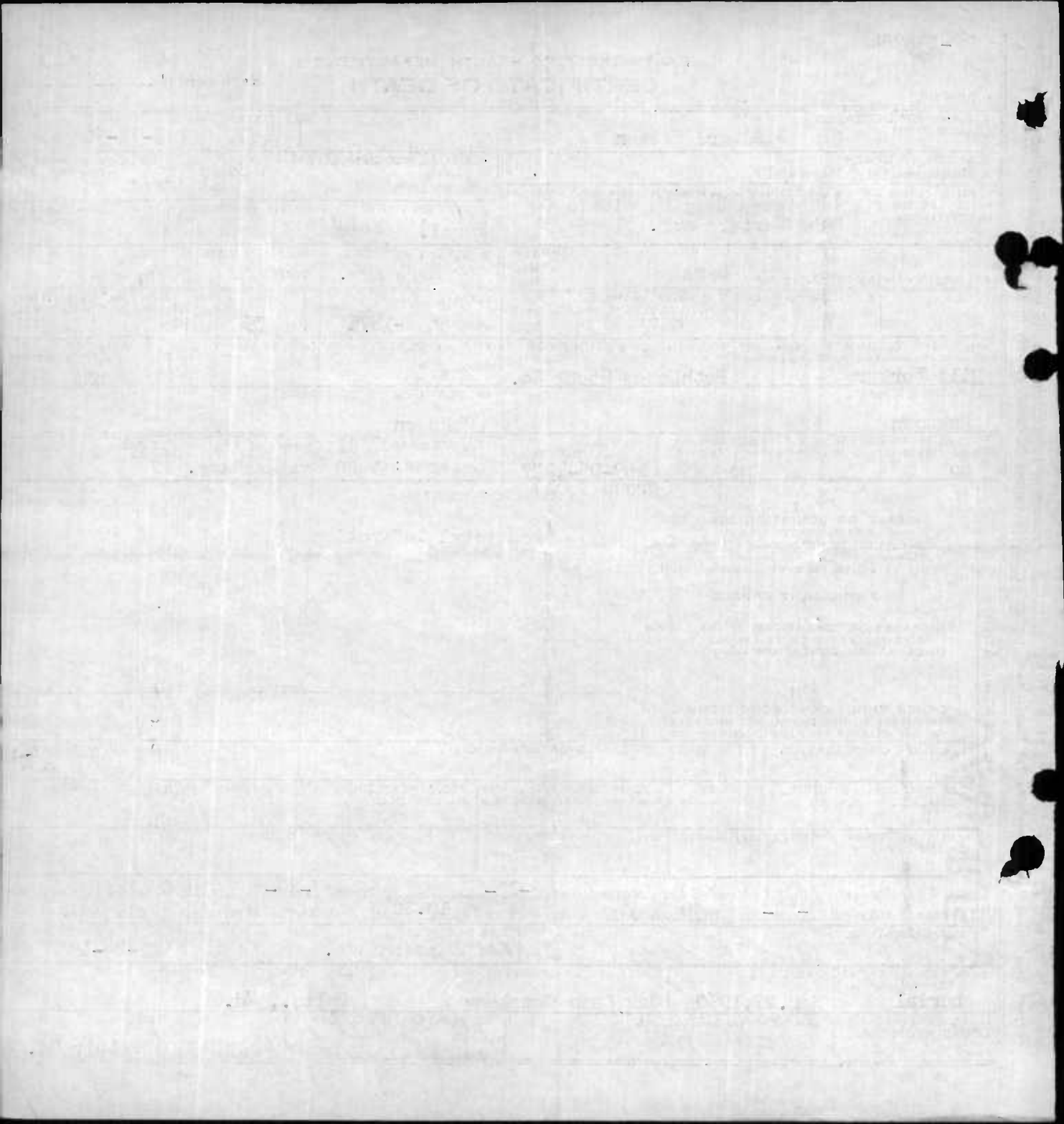
Inquire for primary set  
if known.

Letter in document file 50-2804 - 5/4/50.











PLEASE WRITE PRINTED WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

RESERVED FOR BINDING

MEDICAL CERTIFICATION

VS 150

106B

H-400 MS-135788 50 2806 BIRTH NO. 71901		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 2806 Registered No.	
1. NAME OF DECEASED (Type or Print) <u>Mary Phyllis Hill</u>			2. DATE OF DEATH <u>March 22, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-02</u>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR <u>Baltimore City Hospitals</u> INSTITUTION <u>4940 Eastern Ave.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore <u>life</u> Yrs. <u>life</u> Mos. <u>life</u> Days <u>life</u>			D. STREET ADDRESS (If rural, give location) <u>1428 Wilmer Court Zone 17</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 23, 1947</u>	9. AGE (In years last birthday) <u>3</u>	10. Under 1 Year Months: <u>3</u> Days: <u>3</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Infant</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>over</u>		
13. FATHER'S NAME <u>George Hill</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Giles</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT <u>Records--B.C.H.--4940 Eastern Ave.</u>			ADDRESS		
18. <u>526X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchiectasis</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <u>over</u>		
19A. DATE OF OPERATION <u>2</u>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>			21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <input type="checkbox"/>		
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>2-14</u> , 19 <u>50</u> to <u>3-22</u> , 1950, that I last saw the deceased alive on <u>3-22</u> , 1950, and that death occurred at <u>3:00P m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>R. Argen</u>			23B. ADDRESS <u>B.C.H.--4940 Eastern Ave.</u>		
23C. DATE SIGNED <u>3-24-50</u>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3/27/50</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>			24D. LOCATION (City, town, or county) (State) <u>Cedar Hill</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 27 1950</u>			REGISTRAR'S SIGNATURE <u>W. Helstead</u>		
25. FUNERAL DIRECTOR <u>W. Helstead</u>			ADDRESS <u>418 -</u>		



Write Dr Rogers.  
and ask for autopsy  
findings.

Letter in document file 50-2806-5/4/50.



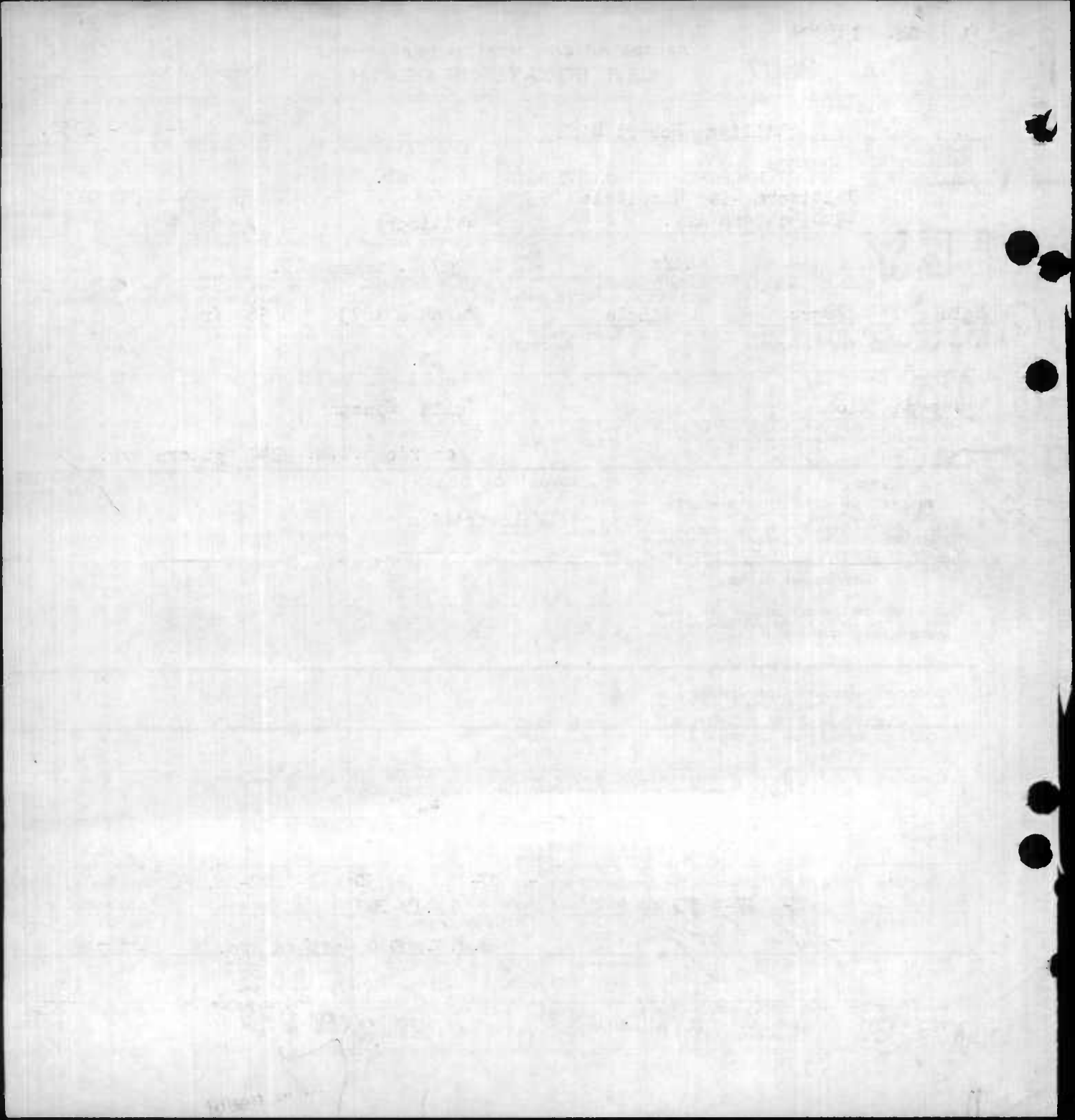
**R-200** IN. 135949  
**50 2807**  
**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**  
Registered No. **50 2807**

**BIRTH NO.**

<b>1. NAME OF DECEASED</b> (Type or Print) <b>William Robert Rich</b>		<b>2. DATE OF DEATH</b> <b>2- 27- 1950.</b>	
<b>3. PLACE OF DEATH:</b> <b>A. Baltimore City, Maryland</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MD.</b> <b>B. COUNTY</b>	
<b>B. FULL NAME OF</b> (If not in hospital or institution, give street address or location) <b>HOSPITAL OR INSTITUTE</b> <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		<b>C. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
<b>c. Length of stay in Baltimore</b> <b>Life</b> <b>Yrs.</b> <b>Mos.</b> <b>Days</b>		<b>D. STREET ADDRESS</b> (If rural, give location) <b>307 S. Sharp St.</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Single</b>	<b>B. DATE OF BIRTH</b> <b>March 8 1893</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>	<b>9. AGE (In years last birthday)</b> <b>56 Yrs.</b>
<b>11. BIRTHPLACE</b> (State or foreign country) <b>MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Rich</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Ranson</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>Records B.C.H. 4940 Eastern Ave.</b>
<b>18. 286.5 I CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Malnutrition</b> <b>DUE TO</b> <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b> <b>(B)</b> <b>DUE TO</b> <b>(C)</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>			
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b>		<b>21B. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)	
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21E. INJURY OCCURRED</b> <b>WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 2- 20- , 19 50 to 2- 27- , 1950, that I last saw the deceased alive on 2- 27- 19 50, and that death occurred at 11:18 PM from the causes and on the date stated above.</b>			
<b>23A. SIGNATURE</b> <i>[Signature]</i>		<b>23B. ADDRESS</b> <b>B.C.H. 4940 Eastern Ave.</b>	<b>23C. DATE SIGNED</b> <b>2-3-7-50</b>
<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b>	<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>UNIVERSITY MEDICAL SCHOOL</b>
<b>24D. LOCATION (City, town, or county)</b> <b>MAR 2 0 1950</b>		<b>(State)</b>	
<b>DATE RECEIVED BY LOCAL REGISTRAR</b> <b>MAR 27 1950</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	
<b>25. FUNERAL DIRECTOR</b> <b>Commissioner of Health</b>		<b>ADDRESS</b>	

VS 150  
200a







**N-425** MS--129183  
50 2808

**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

Registered No. **50 2808**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Lee Nelson</b>		2. DATE OF DEATH <b>3-7-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1021 N. Wolfe St.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>?</b>	8. DATE OF BIRTH <b>Mar., ? 1865</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>85 (?)</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Records--B.C.H.</b>		ADDRESS <b>4940 Eastern Ave.</b>	

18. <b>332 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cerebral thrombosis</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>5-23-</b> , 19 <b>49</b> , to <b>3-7-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3-7-</b> , 19 <b>50</b> , and that death occurred at <b>5:30P m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>[Signature]</b> M. D.		23B. ADDRESS <b>B.C.H.--4940 Eastern Ave.</b>		23C. DATE SIGNED <b>3-15-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24D. LOCATION (City, town, or county) (State) <b>MAR 20 1950</b>
VS 150		25. FUNERAL DIRECTOR <b>Comp. of Health</b>		ADDRESS

83B



CONFIDENTIAL

INTERVIEW

(1) [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2809

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MAMIE LIBERMAN</b>		2. DATE OF DEATH <b>3/26/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-15</b>	
C. Length of stay in Baltimore <b>30</b> Yrs. <b>Mos.</b> <b>Days</b>		D. STREET ADDRESS (If rural, give location) <b>Levendale</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>76</b>
9. AGE (In years, last birthday) <b>76</b>		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry</b>		14. MOTHER'S MAIDEN NAME <b>Chaye</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Max Cohen</b>		ADDRESS <b>1614 Ruxton Ave</b>	

18. <b>570.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intestinal Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Small Intestinal Volvulus</b>		
DUE TO		
(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>3/26/50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Semi-gangrenous small bowel for several feet.</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/25</b> , 19 <b>50</b> , to <b>3/26</b> , 19 <b>50</b> that I last saw the deceased alive on <b>3/26</b> , 19 <b>50</b> , and that death occurred at <b>9:50</b> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>P. Leonard Desser</b>		23B. ADDRESS <b>Sinai Hospital</b>		23C. DATE SIGNED <b>3/26/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-28-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Mt Carmel</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		24E. NAME OF FUNERAL DIRECTOR <b>Jack Lewis</b>		24F. ADDRESS <b>2100 Eutan Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md</b>		25. FUNERAL DIRECTOR'S ADDRESS	







W-512

50 2810

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2810

Registered No. \_\_\_\_\_

BIRTH NO. 50-04308

1. NAME OF DECEASED (Type or Print) BABY HENRY WEINBECK 2. DATE OF DEATH 3-26-50

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE \_\_\_\_\_ B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location) 34 BON SECOURS C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-03

D. STREET ADDRESS (If rural, give location) 3726 Elmley Ave. c. Length of stay in Baltimore Yrs. Mos. Days \_\_\_\_\_

5. SEX M 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S 8. DATE OF BIRTH 2-27-50 9. AGE (In years last birthday) 0 10. Under 1 Year Months Days 2 27 11. Under 24 Hours Hours Min. \_\_\_\_\_

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) \_\_\_\_\_ 10B. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (State or foreign country) Baltimore 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Weinbeck 14. MOTHER'S MAIDEN NAME Anna Goralaki

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Henry Weinbeck ADDRESS 3726 Elmley Ave.

18. 493X I 7630 CAUSE OF DEATH Pneumonia DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 91 to 132 age DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) \_\_\_\_\_ DUE TO (C) \_\_\_\_\_ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT. \_\_\_\_\_

19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 3-20, 1950, to 3-26, 1950, that I last saw the deceased alive on 3-26, 1950, and that death occurred at 7 A m., from the causes and on the date stated above.

23A. SIGNATURE D. S. Schroeder M. D. 23B. ADDRESS Bon Secours Hosp. 23C. DATE SIGNED 3/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/27/50 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem. 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR MAR 27 1950 REGISTRAR'S SIGNATURE Walter W. Williams 25. FUNERAL DIRECTOR John J. Moran ADDRESS 23000 E. Balto. St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and leg.

MEDICAL CERTIFICATION



Mr. Toluck changed order

493x to 763.0

5/11/51



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632  
50 2811

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2811  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <i>CATHERINE SCHWARTZ</i>	
2. DATE OF DEATH <i>3/15/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>West Baltimore General Hosp</i>	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>2003 Homewood Ave</i>	
D. STREET ADDRESS (If rural, give location) <i>Balti</i> <i>9-08</i>	
c. Length of stay in Baltimore Yrs. Mos. Days	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	
8. DATE OF BIRTH <i>July 15, 1872</i>	
9. AGE (In years last birthday) <i>77</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Balti. md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas Campbell</i>	
14. MOTHER'S MAIDEN NAME <i>Brigit Craven</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Miss Marie Schwartz</i>	
ADDRESS <i>2003 Homewood Ave</i>	
18. <i>572.1</i> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) <i>Pneumonia acute</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Ruptured diverticulitis, sigmoid</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <i>Arterioscl. C.V. disease</i>	
19A. DATE OF OPERATION <i>0</i>	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/8/50</i> , 19 <i>50</i> , to <i>3/20/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/20/50</i> , 19 <i>50</i> , and that death occurred at <i>6:30 A</i> m., from the causes and on the date stated above.	
23A. SIGNATURE <i>J. J. Sheen</i> M. D.	
23B. ADDRESS <i>W 35th</i>	
23C. DATE SIGNED <i>3/20/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>6/29/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR	
REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>John A. Morgan</i>	
ADDRESS <i>3000 E. Balto. St.</i>	

MAR 27 1950  
VS 150

93D



CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Color \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Education \_\_\_\_\_

Religion \_\_\_\_\_

Place of Birth \_\_\_\_\_

Usual Residence \_\_\_\_\_

Place of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Cause of Death \_\_\_\_\_

Manner of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

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CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Age at Death		Sex	
Cause of Death		Occupation	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If any item is especially important, Physicians: please write the causes of death clearly and legibly.

500  
50 2813

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2813

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John E. Nine</b>		2. DATE OF DEATH <b>3/25/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>120 S. Calhoun St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>120 S. Calhoun St.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, DIVORCED, WIDOWED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 1879</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work or business, if retired, state of working life, even if retired) <b>Retired Hair Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hair Goods Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Wilbert L. Nine, 6102 Falls Rd, Balto. 9</b>	
18. <b>148 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Throat</b> DUE TO <b>Trunk</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Carcinoma of Throat</b> DUE TO <b>Trunk</b> (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Dec 29, 1949</b> to <b>March 25, 1950</b> , that I last saw the deceased alive on <b>March 23, 1950</b> and that death occurred at <b>1230 PM</b> on the date stated above.					
23A. SIGNATURE <b>R. Johnson</b>		23B. ADDRESS <b>403 Medart, Balto.</b>		23C. DATE SIGNED <b>3-26-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/27/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western, Edmondson Ave. &amp; Longwood St. Balto. Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>Harry T. Wolfe</b>		ADDRESS <b>74101 Edmondson Ave.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, Jr.</b>		VS 150	

49643

45F



CERTIFICATE OF DEATH

1/25/10

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1/25/10



MS--135914

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2814

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Katherine Ida Walther

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

760 Linard St.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 24, 1876

9. AGE (In years  
last birthday)

73

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles V. Walther

14. MOTHER'S MAIDEN NAME

Norah Mullen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records\* Balto. City Hospitals

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Arteriosclerotic Heart Disease

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 2-19-1950 to 3-26-1950, that I last saw the  
deceased alive on 3-26-1950 and that death occurred at 8:30AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B. C. H. -- 4940 Eastern Ave.

Mar. 26, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/29/50

Western

Longwood + Calverton Ave

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Huntington Williams, Jr.

Harold H. Nitzke 4101 Calverton



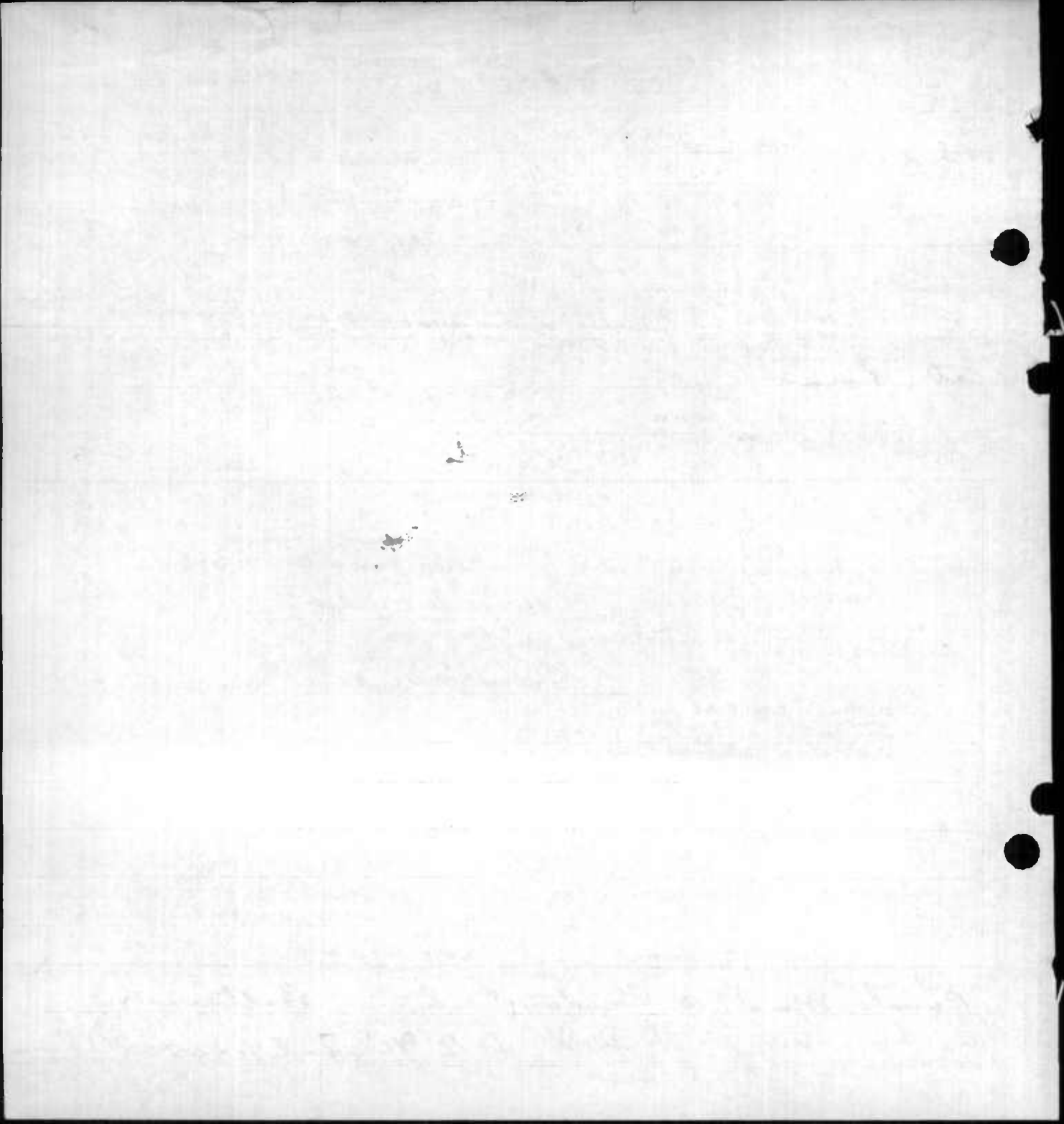




PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information shown is extremely important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

50 2815		BALTIMORE CITY HEALTH DEPARTMENT		50 2815	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
Marie Schultz			March 24, 50		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1815 N Bond St			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION No			C. CITY OR TOWN (If outside corporate limits, write RULE 41 and give township) Baltimore Md 8-05		
D. STREET ADDRESS (If rural, give location) 1815 N Bond St			E. LENGTH OF STAY IN BALTIMORE Life		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 5 1882	9. AGE (In years; last birthday) 67	10. UNDER 1 YEAR Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME George W Soine		
14. MOTHER'S MAIDEN NAME Eugene Sigler			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO. No			17. INFORMANT Mrs Clark		
18. 410 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY ENDEMIC Arterio Sclerosis Hypertension ANTECEDENT CAUSES Malignant Hypertension DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. CHRONIC INFLAMMATORY NEPHRITIS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 2 hr 2 hr 2 hr		
19A. DATE OF OPERATION No			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I hereby certify that I attended the deceased from March 1, 1950, to March 24, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 3 a.m., from the causes and on the date stated above.		
23A. SIGNATURE J. H. F. A. Stevens			23B. ADDRESS 2878 Hartford Rd		
23C. DATE SIGNED 3-24-50			24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		
24B. DATE March 27/50			24C. NAME OF CEMETERY OR CREMATORY London Park		
24D. LOCATION (City, town, or county) (State) Baltimore			25. FUNERAL DIRECTOR Alban J. Thomas Home 2008 Calumet		
DATE RECEIVED BY LOCAL REGISTRAR MAR 27 1950			REGISTRAR'S SIGNATURE Huntington Andrews, MD		







1-654

CERTIFICATE CORRECTED 8-22-50

50 2816

50 2816-136709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

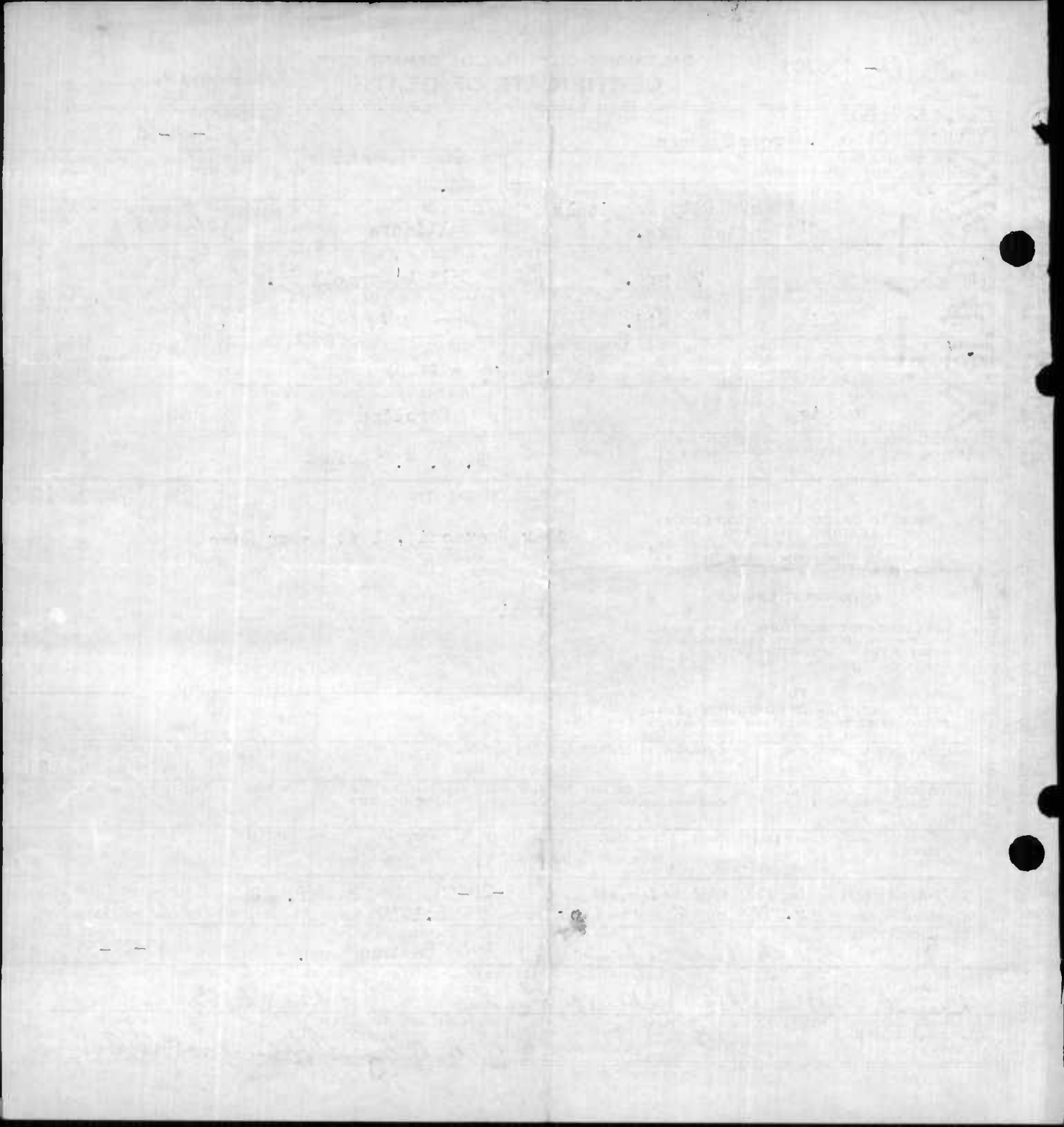
1. NAME OF DECEASED (Type or Print) <b>Otto A. Dromelhausen</b>		2. DATE OF DEATH <b>3-24-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma.</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>26-09</b>	
c. Length of stay in Baltimore <b>70 yrs.</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>3515 O'Donnell St.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>May 3, 1869</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laboren</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Highway Dept</b>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
13. FATHER'S NAME <b>Ludwig</b>		14. MOTHER'S MAIDEN NAME <b>Caroline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>B. C. H. Records</b>		ADDRESS _____	

18. <b>490 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Lobar Pneumonia, left Lower Lobe</b> DUE TO (A) _____ ANTECEDENT CAUSES (B) <b>Uremia</b> DUE TO (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> No <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3-20-50</b> , 19____, to <b>Mar. 24</b> , 19 <b>50</b> that I last saw the deceased alive on <b>Mar. 24</b> , 19 <b>50</b> and that death occurred at <b>6.17AM.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>G. S. Crozer</b> M. D.	23B. ADDRESS <b>4940 Eastern Ave.</b>	23C. DATE SIGNED <b>3-24-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Mar 28/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>
24D. LOCATION (City, town, or county) (State) <b>Balt Co</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams</b>	25. FUNERAL DIRECTOR <b>W. H. Lynd</b> ADDRESS <b>Home 2008 Chelms</b>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2817

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MR. RADA MARKOV</b>		2. DATE OF DEATH <b>3/25/50.</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Ind.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>43 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>1310 Kuper St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>9/18/80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		9. AGE (In years last birthday) <b>69</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing (M)</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>	
13. FATHER'S NAME <b>Not known</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
16. SOCIAL SECURITY NO. <b>216-09-0780</b>		17. INFORMANT <b>W. H. Fay</b>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Obstructive jaundice on portal cirrhosis</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pulmonary atelectasis</b>	(A) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Peripheral vascular collapse</b>	(B) DUE TO	
	(C)	

19A. DATE OF OPERATION <b>3/24/50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Common bile duct obstruction</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3/19</b> , 19 <b>50</b> , to <b>3/25</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3/25</b> , 19 <b>50</b> , and that death occurred at <b>12:50 A.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>John K. Mallen</b>	23B. ADDRESS <b>Bon Secours Hosp</b>	23C. DATE SIGNED <b>3/25/50</b>

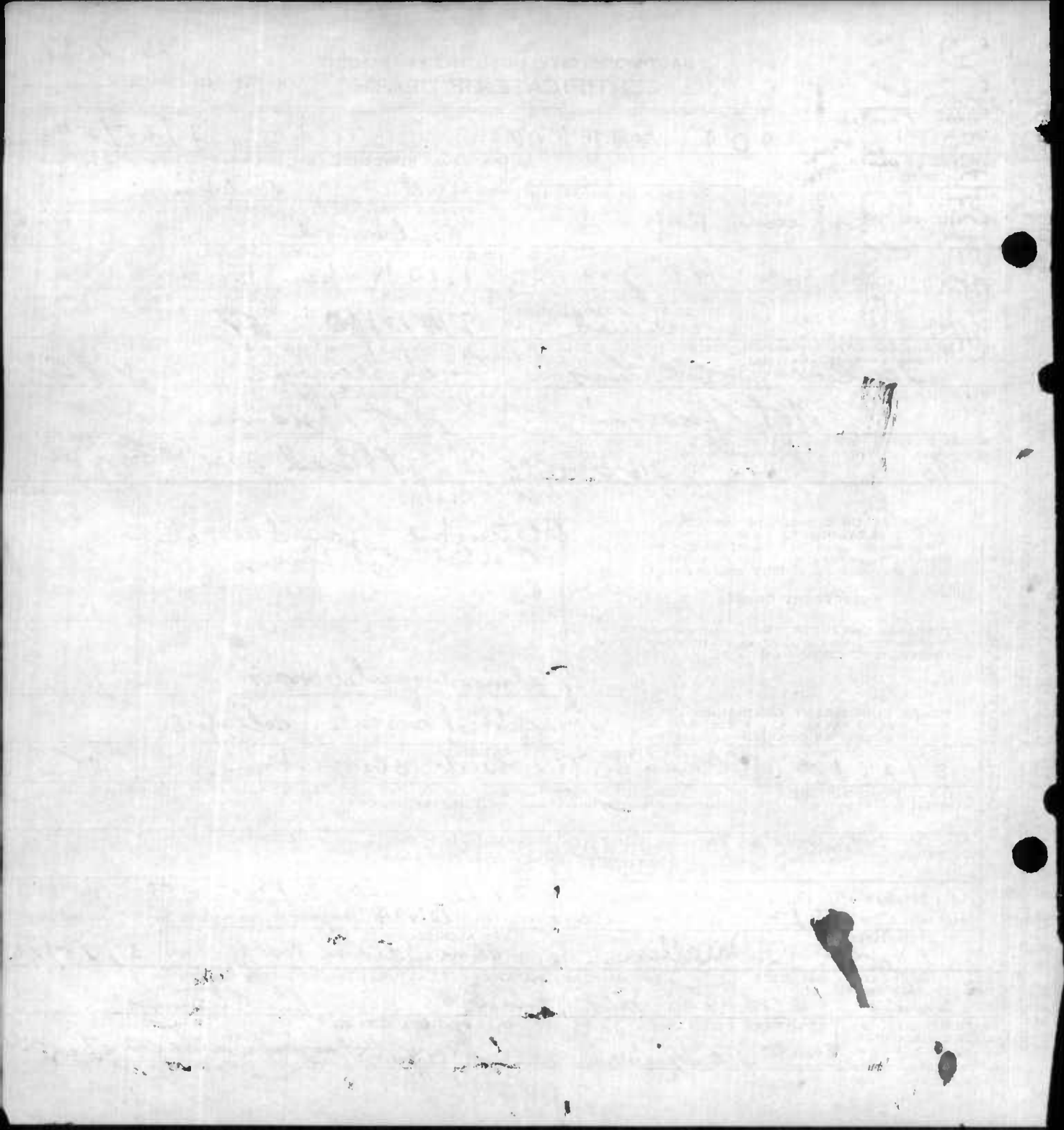
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-18-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>	25. FUNERAL DIRECTOR <b>George A. Ford</b>	

VS 150

360 06

127B







\_\_\_\_\_



CENTRAL OFFICE OF DEATH

Case No. 100-100000

John Doe

John Doe

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied in full and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2819  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elsie May Boyd

2. DATE  
OF  
DEATH

Mar. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4106 Fifth St.

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

James Beacock

15. (Was deceased ever in U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

155-07-3773

17. INFORMANT ADDRESS

18. 443X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular  
Disease

INTERVAL BETWEEN  
ONSET AND DEATH

3 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Rammer, Jr.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Mar. 26, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Mar. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

Chestnut Grove

24D. LOCATION (City, town, or county)

Elmer. N. J.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

Thurston H. Hays

25. FUNERAL DIRECTOR

3311 Edmondson Ave. - John F. Tengel

ADDRESS



STATE OF NEW YORK



525

50 2820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 2820

BIRTH NO.

Unidentified

1. NAME OF DECEASED (Type or Print)

Unidentified

2. DATE OF DEATH

March 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION

Found in sewer at 328 W. Hoffman St.

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

11-04

7. STREET ADDRESS (If rural, give location)

Found in sewer at 328 Hoffman St.-W

8. Length of stay in Baltimore

Yrs. Mos. Days

9. SEX

Female

10. COLOR OR RACE

C ?

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

12. DATE OF BIRTH

13. AGE (In years last birthday)

Approx. 1

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

15. KIND OF BUSINESS OR INDUSTRY

16. BIRTHPLACE (State or foreign country)

Unknown

17. CITIZEN OF WHAT COUNTRY?

18. FATHER'S NAME

Unknown

19. MOTHER'S MAIDEN NAME

Unknown

20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Unknown

21. SOCIAL SECURITY NO.

22. INFORMANT

Unknown

23. ADDRESS

24. CAUSE OF DEATH

18. E 983 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Submersion in sewer

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

25. INTERVAL BETWEEN ONSET AND DEATH

26. DATE OF OPERATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES

NO

27. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Found in sewer at 328 W. Hoffman

30. TIME (Month) (Day) (Year) (Hour) OF INJURY

March 14, 1950 ? m.

31. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

32. HOW DID INJURY OCCUR?

Found in sewer

33. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

34. SIGNATURE

RS Fisher

35. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER

36. DATE SIGNED

March 15, 1950

37. BURIAL, CREMATION, REMOVAL (Specify)

38. DATE

39. NAME OF CEMETERY OR CREMATORY

40. LOCATION (City, town, or county) (State)

JOHN HOPKINS MEDICAL SCHOOL MAR 15 1950

41. DATE RECEIVED BY LOCAL REGISTRAR

42. REGISTRAR'S SIGNATURE

43. FUNERAL DIRECTOR

44. ADDRESS

VS 151

N-990

168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

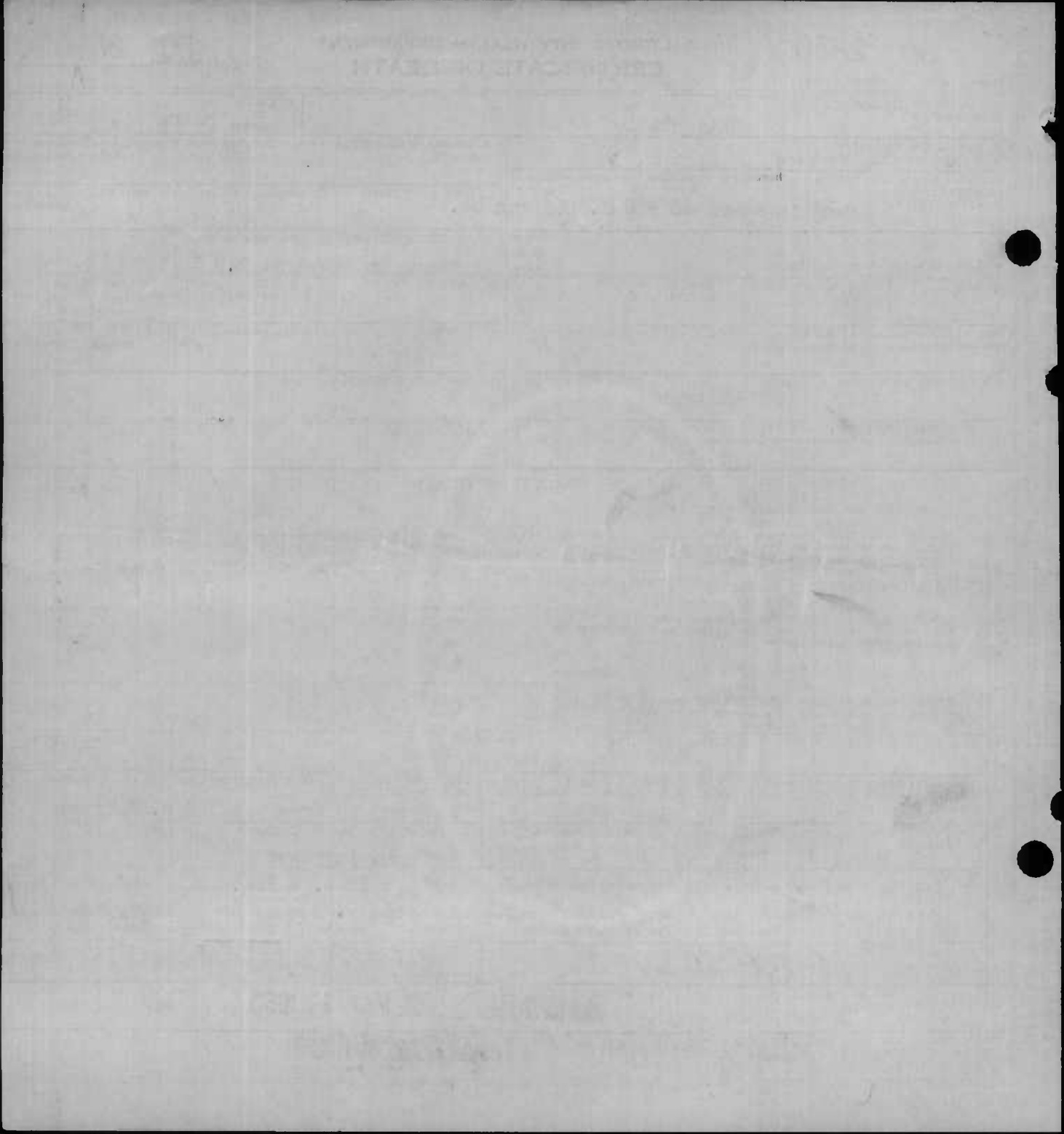
MEDICAL CERTIFICATION

VS 151

N-990

168











CERTIFICATE OF DEATH

1942

1943

1944

1945

1946

1947

1948

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1951

1952

1953

1954

1955

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MS--135947

50 2822

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clement Dyson

2. DATE  
OF  
DEATH

3-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 N. Carey St.

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Nov. 14, 1887

9. AGE (In years  
last birthday)

62

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Marcelus Dyson (Dec.)

14. MOTHER'S MAIDEN NAME

Mary Herbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records--4940 Eastern Ave.

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive arteriosclerotic heart  
disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 2-20-1950, to 3-5-1950 that I last saw the  
deceased alive on 3-5-1950 and that death occurred at 7:00A.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B.C.H.--4940 Eastern Ave.

3-15-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Huntington Williams, M.D.

Commissioner of Health

VS 150

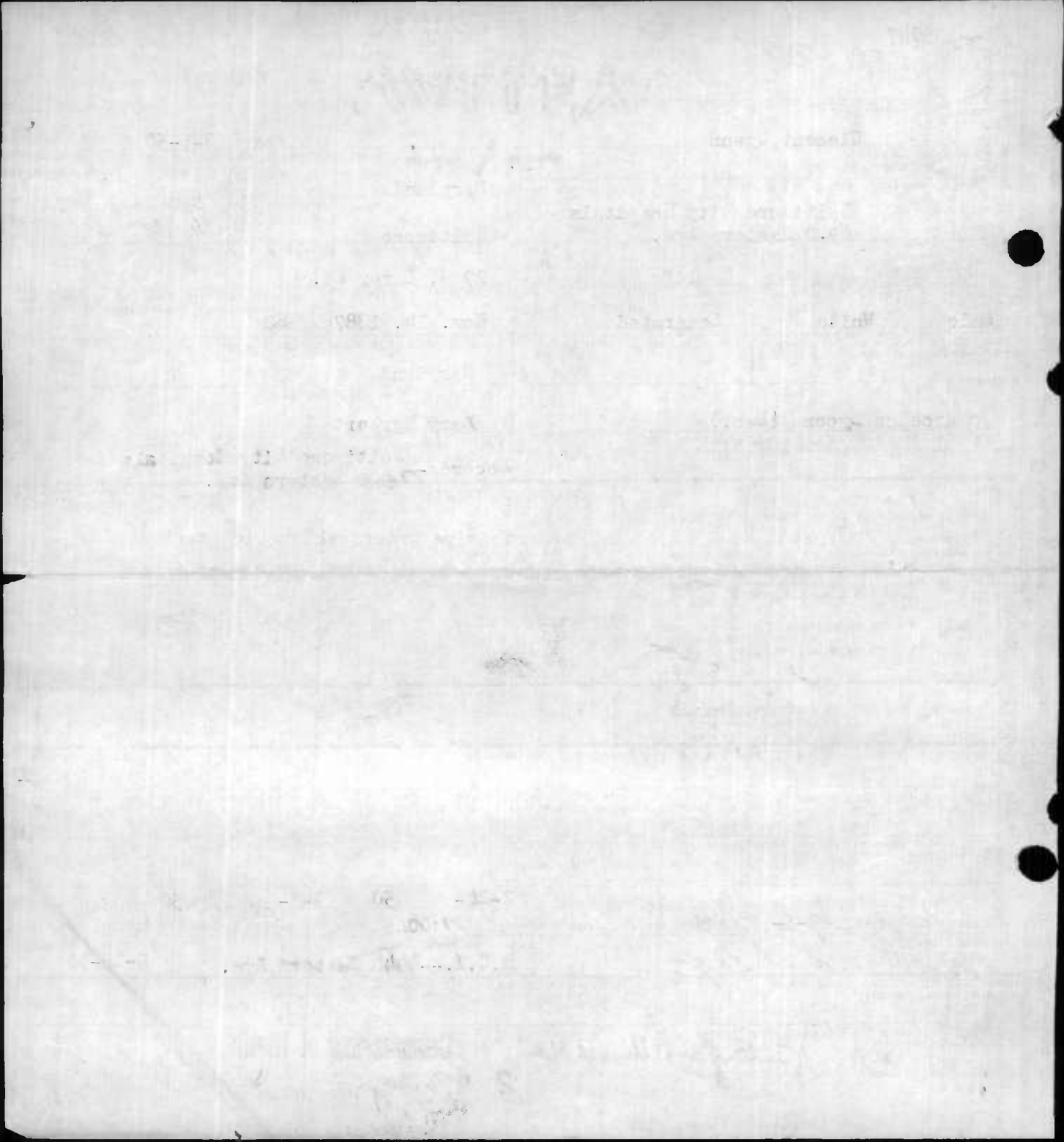
2824

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The data should be carefully supplied.

MEDICAL CERTIFICATION







232  
50 2823

GANDZICKI

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2823

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Josephine Barbara Gajdzicki

2. DATE  
OF  
DEATH

March 25-1950

3. PLACE OF DEATH

A. Baltimore City, Maryland Balto City

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location)

216 S. Chester St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. 2-01

D. STREET ADDRESS (If rural, give location)

216 S. Chester St.

c. Length of stay in Baltimore

11

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Mar. 19, 1882

9. AGE (In years: last birthday)

68

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

yes

13. FATHER'S NAME

Ludwik Rzeposzynski

14. MOTHER'S MAIDEN NAME

Maryanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Pearle Cooper 35 Crest St Westwood N. J.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 13, 1950, to March 25, 1950 that I last saw the deceased alive on March 25, 1950, and that death occurred at 1 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Ludwik Rzeposzynski

M. D.

23B. ADDRESS

2579 Eastern Ave.

23C. DATE SIGNED

3/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 28-1950

24C. NAME OF CEMETERY OR CREMATORY

St. Nicholas

24D. LOCATION (City, town, or county)

Lodi N. J.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

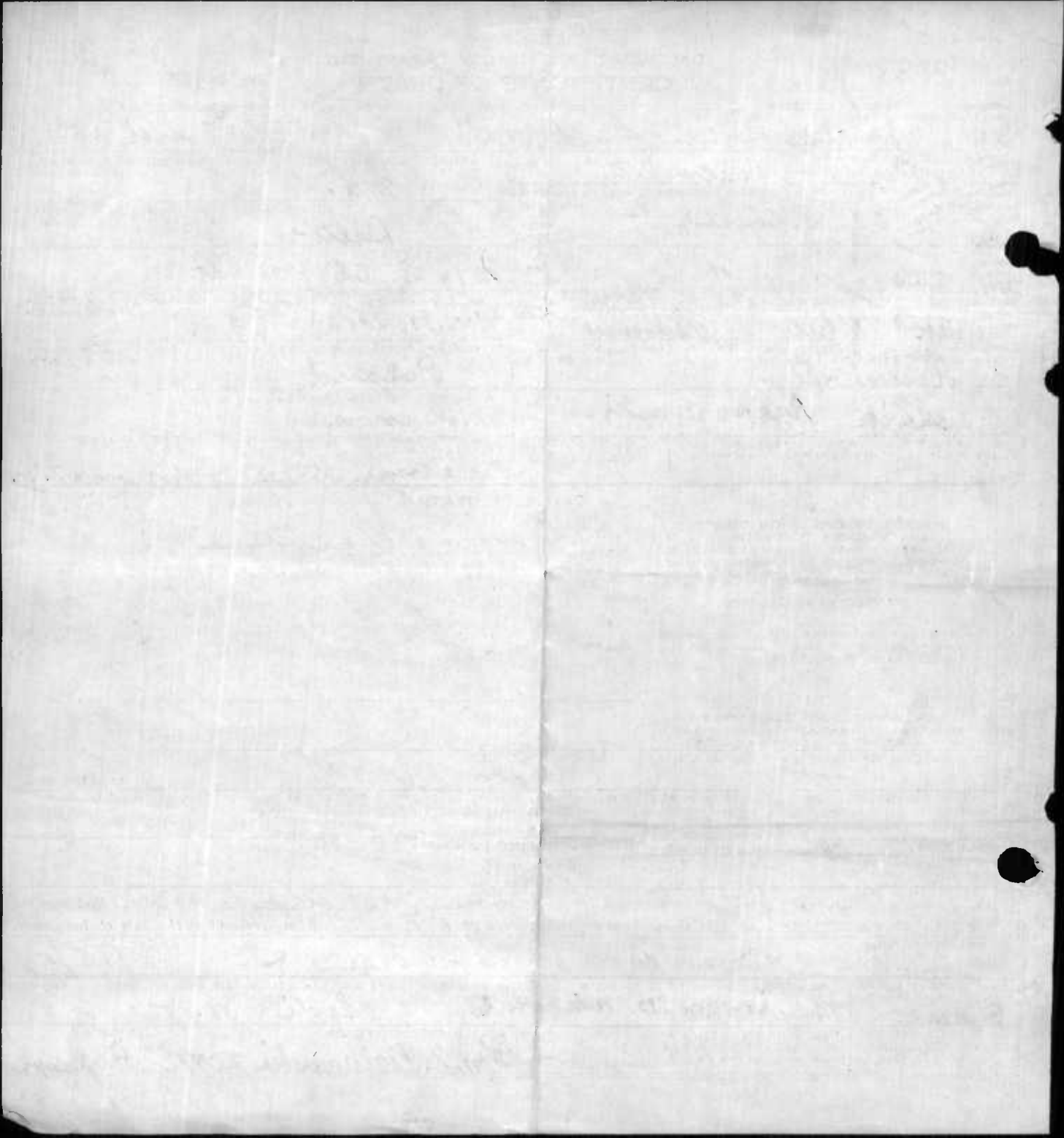
Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. S. Fialkowski 2007 Eastern Ave.







PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2824  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary T. Walker

2. DATE  
OF  
DEATH

3/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

612 Hillview Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

25-02A

D. STREET ADDRESS (If rural, give location)

612 Hillview Rd., Cherry Hill

c. Length of stay in Baltimore

20 Yrs

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Weldon, N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Randol Bonds

14. MOTHER'S MAIDEN NAME

Angeline Sweat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Robert Bonds- 4 W. Heneritta St

18. 002X,

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

8 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/22, 1950, to 3/23, 1950, that I last saw the deceased alive on 3/23, 1950, and that death occurred at 12 p. m. from the causes and on the date stated above.

23A. SIGNATURE

R. R. Johnson

23B. ADDRESS

M. D.

403 Med Arts Bg

23C. DATE SIGNED

3/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Mount Calvary Ct.

24D. LOCATION (City, town, or county)

A.A.Co., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

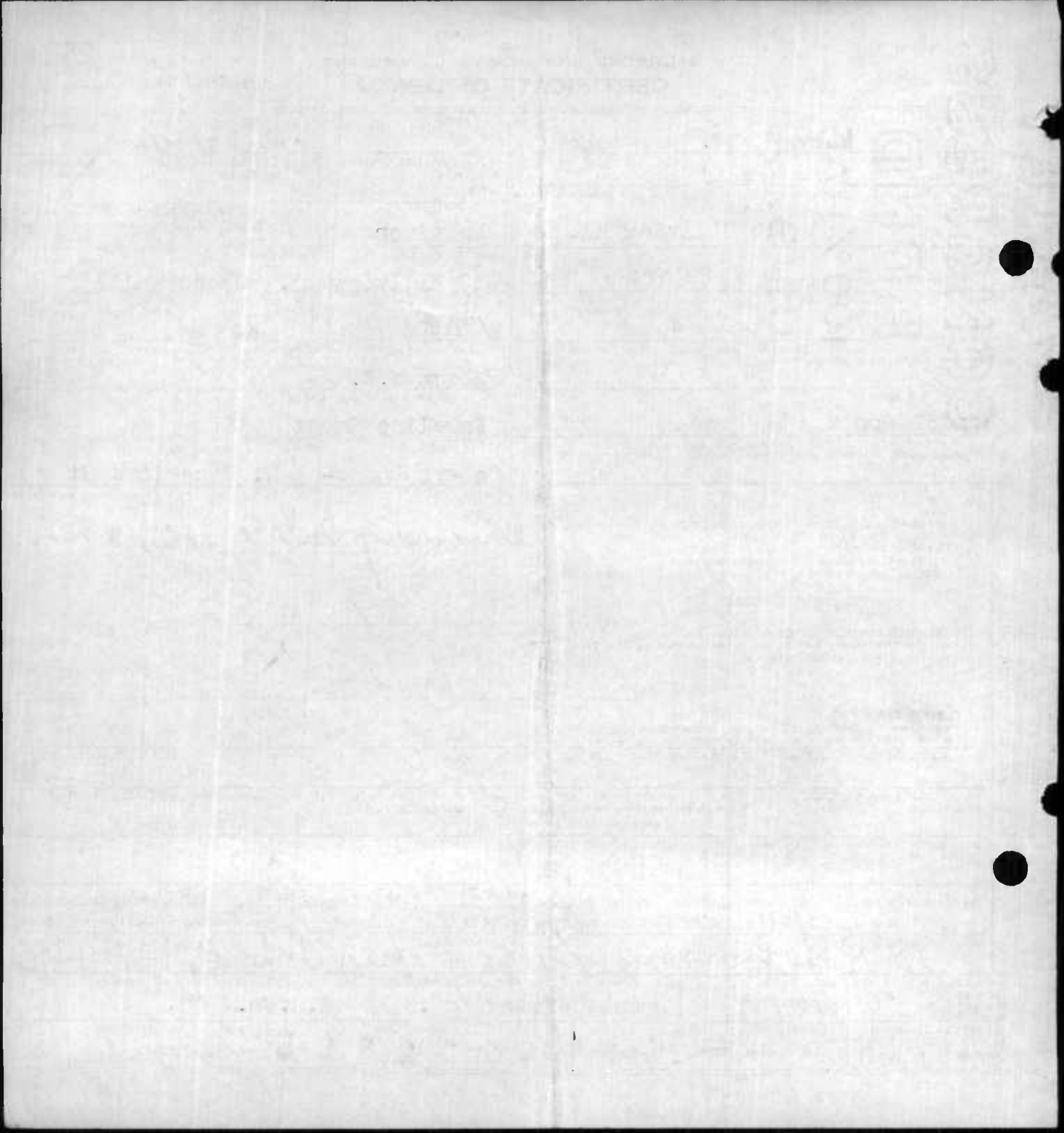
Montgomery Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

W. L. Brown, Jr. - Montgomery







PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

450		CERTIFICATE CORRECTED 3-30-50		50 2825	
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		Walter A. Mullen		2. DATE OF DEATH March 24/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland 1203 N. Washington St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1203 N. Washington St.			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.		8-07	
C. Length of stay in Baltimore life		D. STREET ADDRESS (If rural, give location) 1203 N. Washington St.			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 20, 1877 1878	9. AGE (In years last birthday) 72 yrs 71	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Sign Painter (Self)		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME James Mullen		14. MOTHER'S MAIDEN NAME Margaret Dart K. Aydelott		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Beatrice Mullen, 1203 N. Washington St.	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Arteriosclerosis ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ?	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/22, 1950, to 3/24, 1950, that I last saw the deceased alive on 3/24, 1950, and that death occurred at 10 PM., from the causes and on the date stated above.					
23A. SIGNATURE J. E. Smith		23B. ADDRESS 1223 E. North Ave.		23C. DATE SIGNED 3/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 27/50		24C. NAME OF CEMETERY OR CREMATORY Balto. Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. FUNERAL DIRECTOR Philip H. H. H. H.		24F. ADDRESS 2024 Orleans St.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 27 1950		REGISTRAR'S SIGNATURE Walter A. Mullen		24G. ADDRESS 2024 Orleans St.	



1223 4 4/10/74

7110 5737

RECORDED  
VALLEY



PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

426

50 2826

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2826  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Daniel A. Gallagher</i>		2. DATE OF DEATH <i>3/26/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>4-01</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>110 W Mulberry St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. LENGTH OF STAY IN BALTIMORE <i>4 yrs</i>		E. STREET ADDRESS (If rural, give location) <i>110 W. Mulberry St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3/15/1882</i>
9. AGE (in years, last birth day) <i>68</i>		10. UNDER 1 YEAR Months: Days: Hours: Min.	
11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Shoe Salesman Munnibush &amp; Co.</i>		12. BIRTHPLACE (State or foreign country) <i>Wilmington Delaware</i>	
13. FATHER'S NAME <i>John Gallagher</i>		14. MOTHER'S MARRIAGE NAME <i>Julia Ward</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>James J. Gallagher</i>		ADDRESS <i>707 W. 10th St. Wilmington</i>	
18. <i>434.3</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>C. P. C. Lung</i> <i>Pulmonary Hemorrhage</i> DUE TO <i>Acute Cardiac Dilatation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 da.</i> <i>2 da.</i> <i>2 da.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B) _____ DUE TO _____  (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/20</i> , 19 <i>50</i> , to <i>3/26</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/24</i> , 19 <i>50</i> , and that death occurred at <i>3:11 p.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>D. E. W. Room</i>		23B. ADDRESS <i>1202 St Paul St</i>	
23C. DATE SIGNED <i>3/27/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/29/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Wilmington Delaware</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>		REGISTRAR'S SIGNATURE <i>John J. Lowan</i>	
FUNERAL DIRECTOR <i>John J. Lowan</i>		ADDRESS <i>95C St.</i>	







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2827  
Registered No.

BIRTH NO. 2827

1. NAME OF DECEASED (Type or Print) <b>MISS LILLYE RIEF</b>		2. DATE OF DEATH <b>MARCH 25, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>HAVER NURSING HOME</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b> <b>15-06</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2734 Presbury St.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Feb. 21, - about 74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never worked</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years last birthday) <b>about 74</b>
13. FATHER'S NAME <b>John V. Rief</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. <b>no</b>		14. MOTHER'S MAIDEN NAME <b>Martha E. Dutee</b>	
17. INFORMANT <b>Mrs. Evelyn B. Spindler</b>		ADDRESS <b>Box 2, Balto.23</b>	

18. <b>443 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-vascular accident</b> DUE TO (A) <b>14 days</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (B)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>March 12, 1950</b> , to <b>March 25, 1950</b> , that I last saw the deceased alive on <b>March 19, 1950</b> , and that death occurred at <b>8:45</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>M. Goldstein</b>		23B. ADDRESS <b>5334 Liberty Heights Ave.</b>		23C. DATE SIGNED <b>3/25/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/28/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25. FUNERAL DIRECTOR <b>W. A. TICKNER &amp; SONS</b>		ADDRESS <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>		REGISTRAR'S SIGNATURE <b>W. A. TICKNER</b>		25. FUNERAL DIRECTOR <b>W. A. TICKNER &amp; SONS</b>	
VS 150					

937







P-620  
50 2828

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2828  
Registered No.

BIRTH NO

1. NAME OF DECEASED  
(Type or Print)

Elizabeth M. Price

2. DATE  
OF  
DEATH

Mar. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

13-02

D. STREET ADDRESS (If rural, give location)

717 Lennox St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1419 Bolton St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

B. DATE OF BIRTH

Apr. 15, 1880

9. AGE (In years last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Caleb S. Taylor

14. MOTHER'S MAIDEN NAME

Eleanor Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Miss Eleanor M. Brady 1419 Bolton St.

18. E972

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon Monoxide Poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
Home - Bathroom

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1419 Bolton Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

March 26, 1950 A.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Gas heater on but unlit

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

MEDICAL INVESTIGATOR

23C. DATE SIGNED

Mar. 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/28/50

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill Cem.

24D. LOCATION (City, town, or county)

Towson, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

Wm. H. Kammer, Jr.

25. FUNERAL DIRECTOR

W. A. TICKNER & SONS

ADDRESS

Balto., Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Occupation		7. Cause of Death		8. Signature of Physician	
9. Signature of Registrar		10. Date of Registration		11. Place of Registration		12. Remarks	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No 50 2829

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELIZABETH PATTERSON

2. DATE

OF

DEATH March 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

642 W. Fairmount Avenue

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Unknown

9. AGE (In years last birthday)

31

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

18. 0120 002X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Disseminated tuberculosis

DUE TO tuberculosis of lumbar spine

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

March 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Commissioner of Health

2

Commissioner of Health



00361 Case Card, after <sup>1950</sup> ~~1949~~ on cards -  
(including lungs)

ES 4-17-50



520 50 2830

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2830  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR

JONES

2. DATE  
OF  
DEATH

March 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Unknown

8. DATE OF BIRTH

Unknown

9. AGE (In years  
last birthday)

57

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Unknown

ADDRESS

18. 4m 1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Malnutrition

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arteriosclerotic cardiovascular  
disease

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

P. J. L. L. L.

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

3/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL MAR 20 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

T. J. L. L. L.

25. FUNERAL DIRECTOR

ADDRESS

2 8 Commissioner of Health



CERTIFICATE OF DEATH

11



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2831  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Herman G. Mehlhorn*

2. DATE  
OF  
DEATH

*March 24, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*2332 N. Calvert Street*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

*Baltimore 12-04*

D. STREET ADDRESS (If rural, give location)

*2332 N. Calvert St.*

c. Length of stay in Baltimore

*75*

Yrs.  
Mos.  
Days

5. SEX

*M.*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*M.*

8. DATE OF BIRTH

*Aug. 22, 1867*

9. AGE (In years  
last birthday)

*82*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Unemployed*

10B. KIND OF BUSINESS OR  
INDUSTRY

*—*

11. BIRTHPLACE (State or foreign country)

*Germany*

12. CITIZEN OF  
WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Herman Mehlhorn*

14. MOTHER'S MAIDEN NAME

*Emily*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Ellaine La Porte Mehlhorn, 2332 N. Calvert*

18. *760X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) \_\_\_\_\_  
DUE TO

*Diabetes Mellitus*

INTERVAL BETWEEN  
ONSET AND DEATH

*?*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) \_\_\_\_\_

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from *October, 1949* to *March 24, 1950*, that I last saw the  
deceased alive on *Mar 22, 1950*, and that death occurred at *6.00 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*William F. Pearce*

M. O.

23B. ADDRESS

*2105 N Charles St*

23C. DATE SIGNED

*Mar 25, 1950*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial*

*3/27/50*

*Rowdon Park*

*Baltimore, Md.*

DATE RECEIVED BY  
LOCAL REGISTRAR

*MAR 27 1950*

REGISTRAR'S SIGNATURE

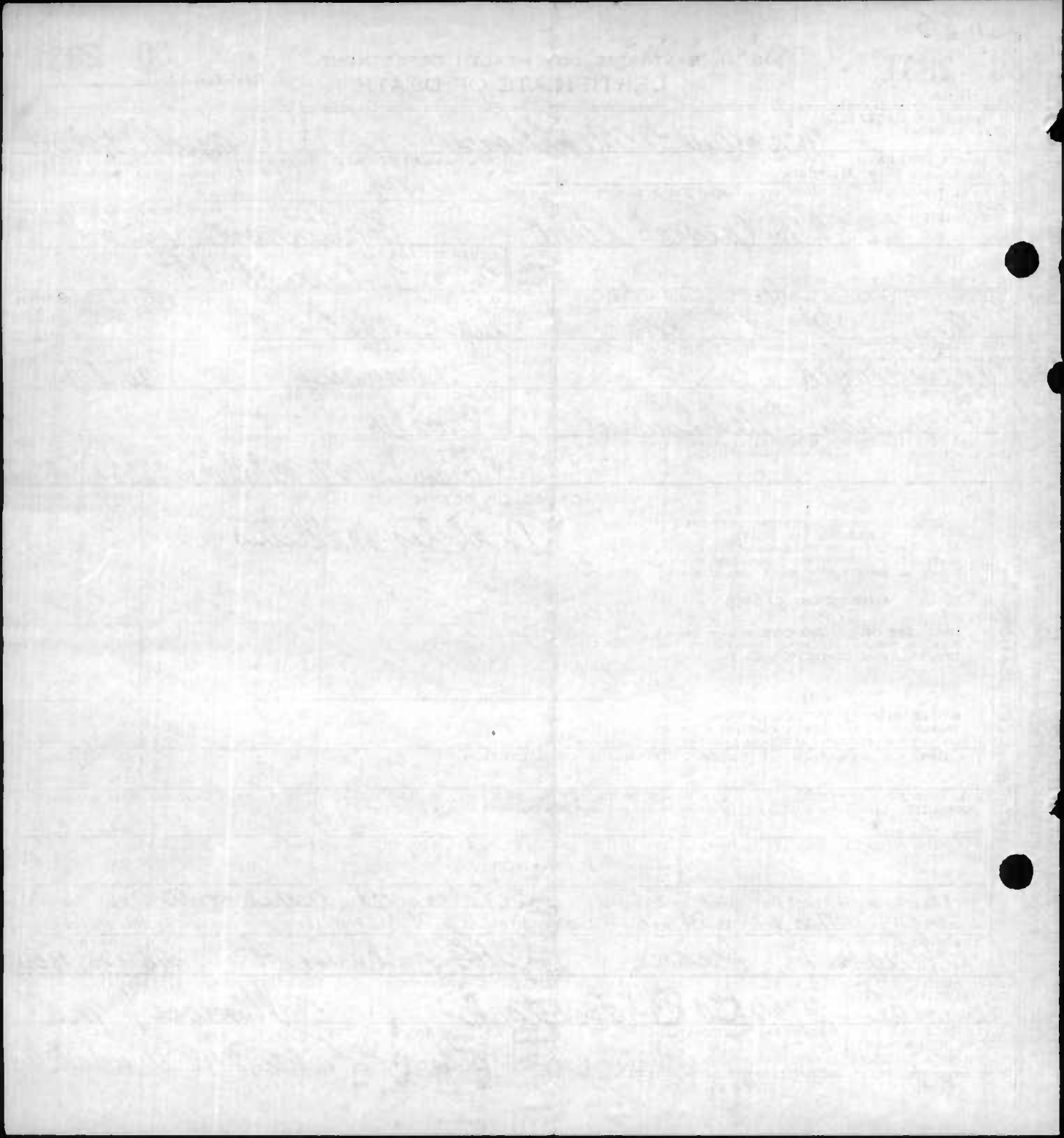
*Huntington Hilligreen*

25. FUNERAL DIRECTOR

ADDRESS

*Roland L. Fisher, 2112 Dandale Ave*







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2832

BIRTH NO. 50-05753

1. NAME OF DECEASED (Type or Print) <b>Baby Girl Straight</b>		2. DATE OF DEATH <b>March 22, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Middle River</b>	
c. Length of stay in Baltimore <b>11 hrs.</b>		D. STREET ADDRESS (If rural, give location) <b>543 Edgewater Apts. # 20</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Mar. 22, 1950</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>11</b> H Under 1 Year Months: Days H Under 24 Hours Hours: Min.
13. FATHER'S NAME <b>Swinburn Forster Straight</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Frances Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Madeline Frances Straight</b> ADDRESS <b>543 Edgewater Apts. # 20</b>	

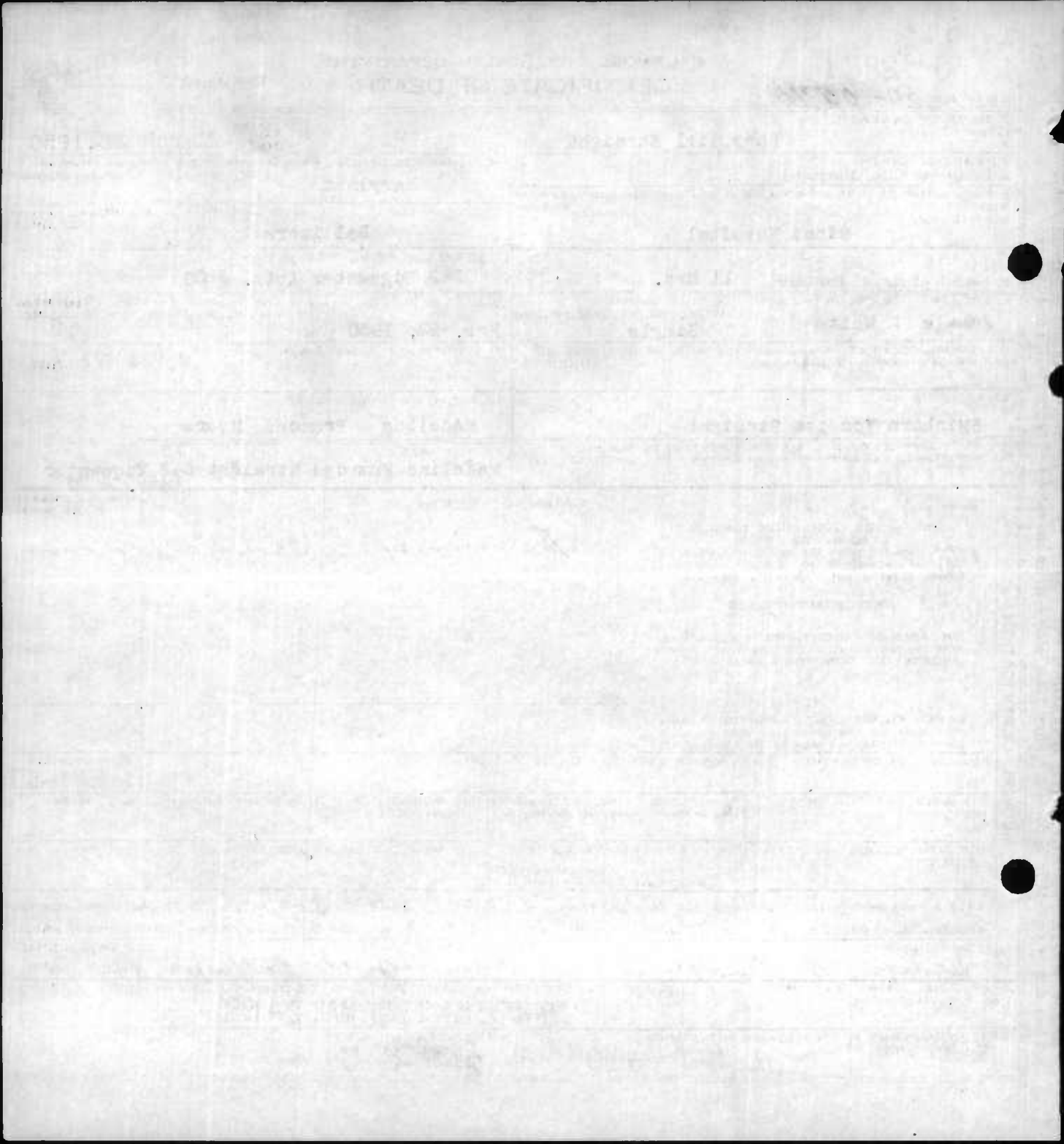
MEDICAL CERTIFICATION

18. <b>776x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Pre-arterial, by severe</b> DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>
---	--	---

19A. DATE OF OPERATION <b>3-22-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3-22-50</b> , 1950, to <b>3-22-50</b> , 1950, that I last saw the deceased alive on <b>3-22-50</b> , 1950, and that death occurred at <b>11 1/2</b> a. m., from the causes and on the date stated above.					
23. SIGNATURE <b>Judith B. Landau</b>		23B. ADDRESS <b>Sinai Hosp. Bal Baltimore</b>		23C. DATE SIGNED <b>3-24-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		24E. REGISTRAR'S SIGNATURE <b>Huntington Halligan</b>		25. FUNERAL DIRECTOR <b>Somerset Health</b>	

JOHN HOPKINS MEDICAL SCHOOL MAR 24 1950







PLEASE PRINT FULL NAME, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2833  
Registered No. 50 2833

BIRTH NO. 50-06049

1. NAME OF DECEASED (Type or Print) Baby Girl Jones		2. DATE OF DEATH Mar. 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Essex	
C. Length of stay in Baltimore 29 Hours.		D. STREET ADDRESS (If rural, give location) 818 Brunswick Rd. # 21	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Mar. 20, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 2	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 2	
13. FATHER'S NAME Donald Beamer Jones		14. MOTHER'S MAIDEN NAME Rose Marie Bodner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT Rose Marie Jones 818 Brunswick Rd. # 21	
16. SOCIAL SECURITY NO.		ADDRESS	

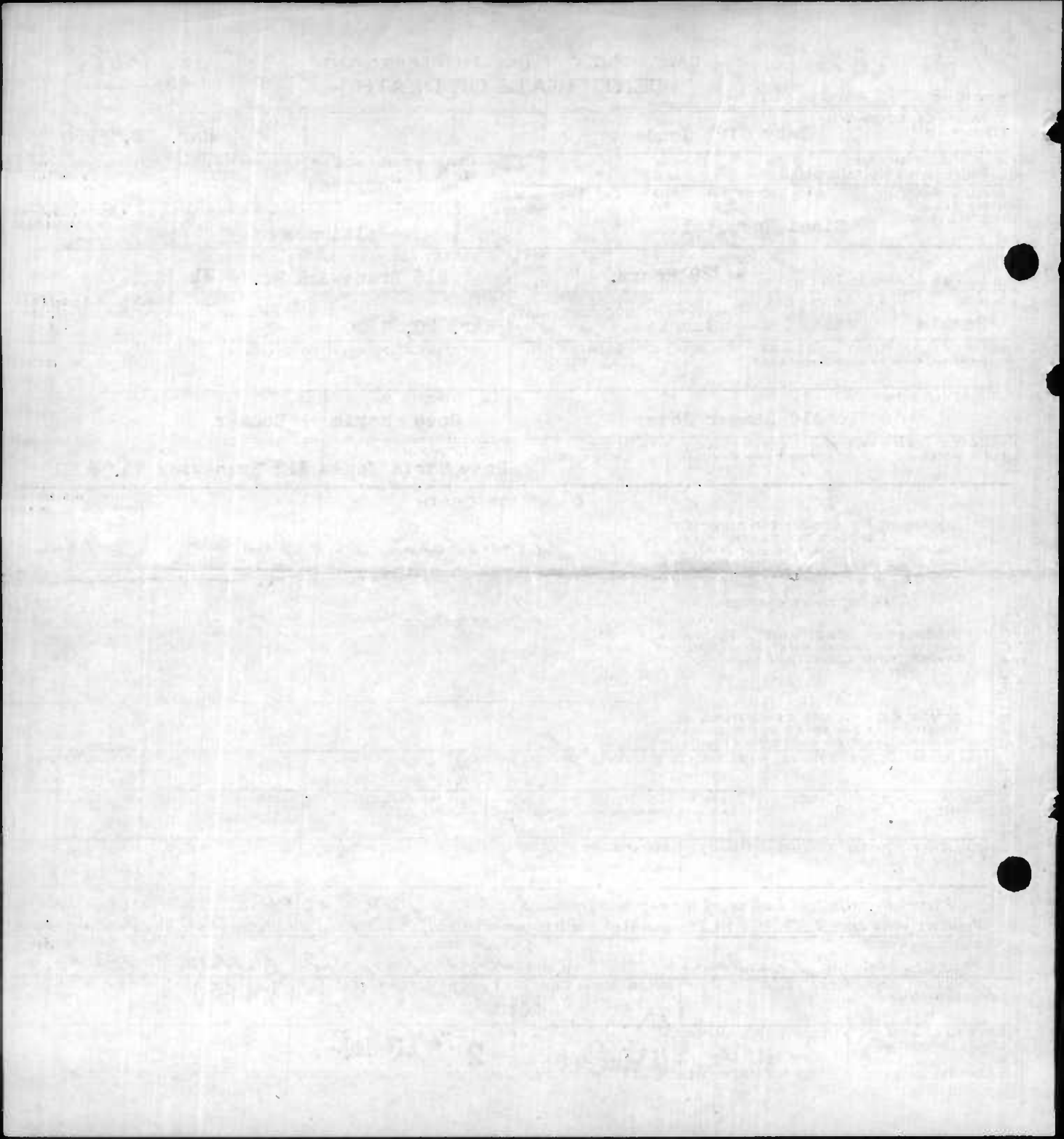
MEDICAL CERTIFICATION

18. 7625 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Atelectasis, Congenital DUE TO (B) Prematurity DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 29 hours
--	---	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-20, 1950, to 3-22, 1950, that I last saw the deceased alive on 3-22, 1950, and that death occurred at 2:50 a. m., from the causes and on the date stated above.					
23A. SIGNATURE Joseph B. Landau		23B. ADDRESS Sinai Hospital, Baltimore		23C. DATE SIGNED 3-24-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		24E. DATE OF DEATH		24F. SIGNATURE OF REGISTRAR	
DATE RECEIVED BY LOCAL REGISTRAR MAR 27 1950		REGISTRAR'S SIGNATURE Huntington Hall		25. FUNERAL DIRECTOR 28 Commissioner of Health	
VS 150				ADDRESS	

159







correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2834

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Charles C. CARRICK*  
*Charles C. Carrick*

2. DATE  
OF  
DEATH

*MAY-25-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*West B Gen Hosp.*

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*West Baltimore Genl Hosp.*

C. Length of stay in Baltimore

*60 yrs*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Married*

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*retired*

10B. KIND OF BUSINESS OR  
INDUSTRY

*W. T. Tel. Co.*

13. FATHER'S NAME

*Charles T. Harrieh*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

*no*

16. SOCIAL  
SECURITY NO.

*315-03-94MA*

17. INFORMANT

*Ms. Harrieh (C. Carrick) (neph.)*

ADDRESS

*Belle*

18. *E 816.4*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Uremia*  
*Nephroclerosis*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Fracture of right hip*

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

*Street*

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

*Cottage & Keyworth Avenues*

*15/12*

21D. TIME (Month) (Day) (Year) (Hour)

*December 27, 1949 8:15P m.*

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

*Passenger in auto and auto collision*

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Earl L. Royer*

23B. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

23C. DATE SIGNED

*26 May 50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/28/50*

24C. NAME OF CEMETERY OR CREMATORY

*Woodlawn*

24D. LOCATION (City, town, or county)

*Belle Co.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

*MAY 27 1950*

REGISTRAR'S SIGNATURE

*Huntington Williams*

25. FUNERAL DIRECTOR

*2525 Moxley. Balto.*

ADDRESS



CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Informant		12. Signature of Coroner	



51 R



UNITED STATES  
DEPARTMENT OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
WASHINGTON, D. C.

Form No. 1  
Prescription

For the use of the  
Veterinary Surgeon

Prescribed by

Signature of Veterinarian

Date

Place

State

County

City

Street

Box

Post Office

State

County

City



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

520  
50 2836

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2836

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Vina Jones

2. DATE  
OF  
DEATH

3/24/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1201 Etting Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

1201 Etting Street

C. Length of stay in Baltimore

20 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 24, 1882

9. AGE (In years  
last birthday)

67

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Notaway Co. Va

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel

Hicks

14. MOTHER'S MAIDEN NAME

Harrett

Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Isabelle Nottage 201 Beal Court

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Cardiovascular Disease 2 yr

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 2-16, 1950, to 3-24, 1950, that I last saw the  
deceased alive on 2-28, 1950, and that death occurred at 8:30 m., from the causes and on the date stated above.

23A. SIGNATURE

W. Atwell Jones

M. D.

23B. ADDRESS

554 Solph Rd

23C. DATE SIGNED

3-22-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/27/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn A.A. Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. Atwell Jones

25. FUNERAL DIRECTOR

ADDRESS

Edw. O. Wilson 1000 Brantly Ave



Mr Jones)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Bessie Jones</i>		2. DATE OF DEATH <i>3-24-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. City</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Provident Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. City 7-05</i>	
c. Length of stay in Baltimore <i>18 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>801 N. Bond St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 16 1909</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Burnsville Co. Va</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHICH COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Jones</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or not known) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Adele Ford</i>		ADDRESS <i>1648 Annie St</i>	

18. <i>331X</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Cerebral hemorrhage</i>	<i>About 24 hrs.</i>
ANTECEDENT CAUSES	(B) <i>Essential hypertension</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2-23-50*, 19*50*, to *2-24-50*, 19*50*, that I last saw the deceased alive on *2-24-50*, 19*50*, and that death occurred at *2:45* p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Lucien C. Kuper, M.D.</i>	23B. ADDRESS <i>Provident Hospital</i>	23C. DATE SIGNED <i>March 25, 1950</i>
--	---	---

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-29-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem</i>	24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>	REGISTRAR'S SIGNATURE <i>Thurston S. Williams, M.D.</i>	FUNERAL DIRECTOR <i>Chas. E. Wilson</i>	
		ADDRESS <i>1000 Beauty</i>	



THE UNIVERSITY OF CHICAGO  
NTA 10 10 1961



2-236

50 2838

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary Pistoria

2. DATE OF DEATH March 25, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2530 Robb St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days  
11. Under 24 Hours Hours: Min.

female white

widowed

Aug. 15, 1882

67

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

house wife

Italy

U.S.

13. FATHER'S NAME

Joseph Uzzo

14. MOTHER'S MAIDEN NAME

Jennie Compo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Joseph Pistorio 2530 Robb St.

18. 443 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic cardiovascular disease with hypertension

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 20, 1950 to March 25, 1950, that I last saw the deceased alive on March 25, 1950, and that death occurred at 9:40 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

J. Salem

M. D.

6217 Highland Rd

3/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/29/50

Holy Redeemer

Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Huntington Williams, M.D.

Clarence F. Hoffmann 1639 Broadway.

VS 150

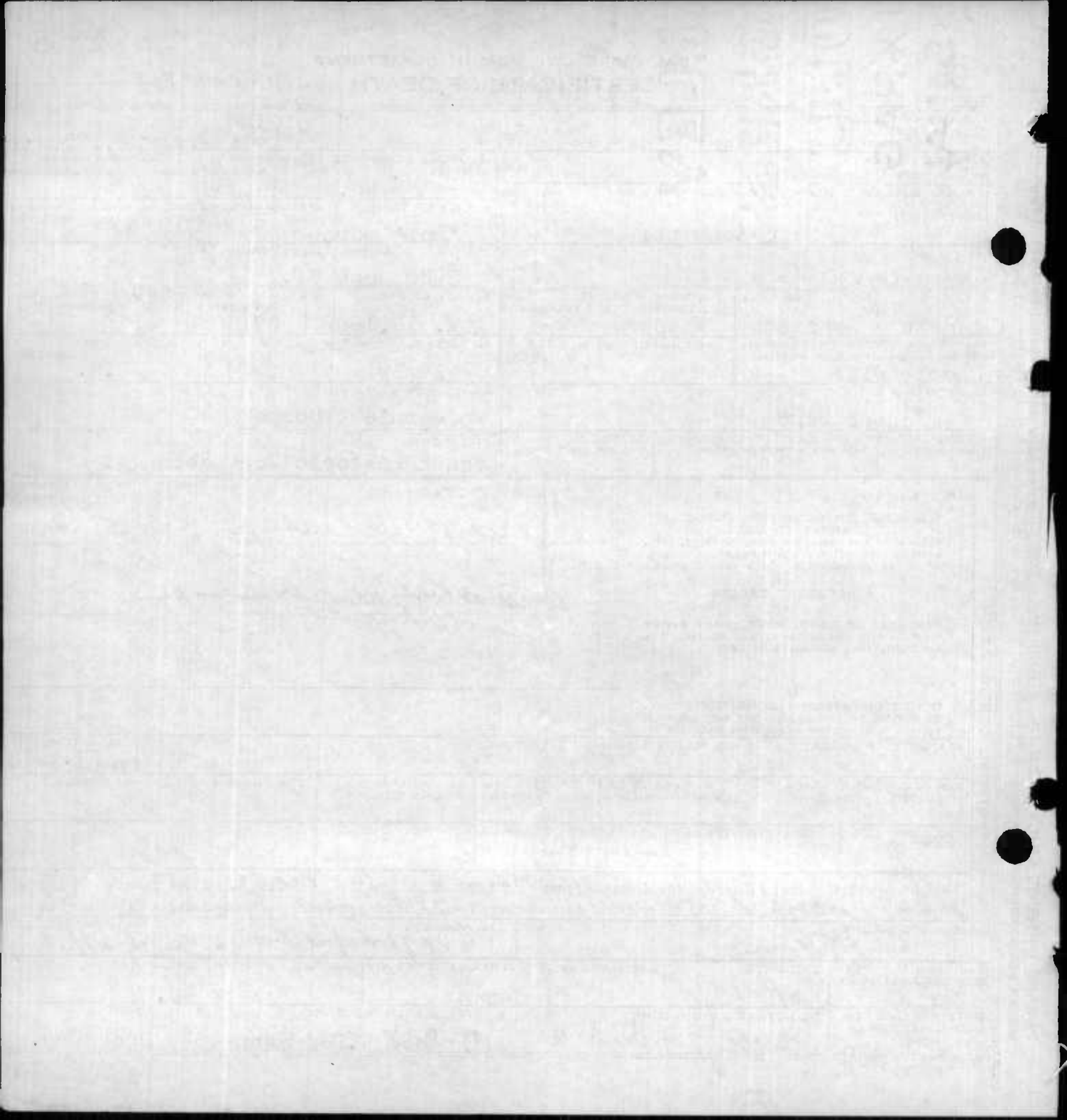
6217

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-652  
50 2839

JERNIGER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2839  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edward Jerniger</i>		2. DATE OF DEATH <i>Mar 12 - 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>681 W. Fayette St</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>681 W. Fayette Street</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>4-02</i>			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>681 W. Fayette St</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>2</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Acute Cardiac Dilatation</i> DUE TO (B) <i>Cardio-vascular disease</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>One day</i>  <i>?</i>	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 15</i> , 1950, to <i>Mar 12</i> , 1950, that I last saw the deceased alive on <i>Mar 12</i> , 1950, and that death occurred at <i>8 A. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Harry Glassman</i>		23B. ADDRESS <i>753 W. Fayette St</i> M. D.		23C. DATE SIGNED <i>Mar 15 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (City, town, or county)	
25A. REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>		25B. FUNERAL DIRECTOR <i>Commissioner of Health</i>		25C. ADDRESS	

UNIVERSITY MEDICAL SCHOOL MAR 27 1950



1912-13

1912-13

1912-13

2615

1912-13

1912-13

1912-13



PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied clearly and legibly. correct age is especially important. Physicians: please write the causes of death.

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2840

50 2840

1. NAME OF DECEASED  
(Type or Print)

ANNIE OBERDAHLHOFF

2. DATE  
OF  
DEATH

MARCH 25 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

ST PAUL CONVALESCENCE HOME

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

FEM

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

JUNE 13-1881

9. AGE (In years

last birthday)

68

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of

work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR

INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF

WHAT COUNTRY?

U.S.

13. FATHER'S NAME

ANDREW ROHDE

14. MOTHER'S MAIDEN NAME

HERRIETTA LETIYATE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS LENA COOPER 808 E 33rd St

18. 174X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) carcinoma, uterus  
metastasis to bowel,  
ascending colon

2 yrs 1

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Left Hemiplegia

1 1/2 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Anterior sclerotic heart,

4 yrs 1

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 2 yrs 1950, to 3/25, 1950, that I last saw the  
deceased alive on 3/25, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

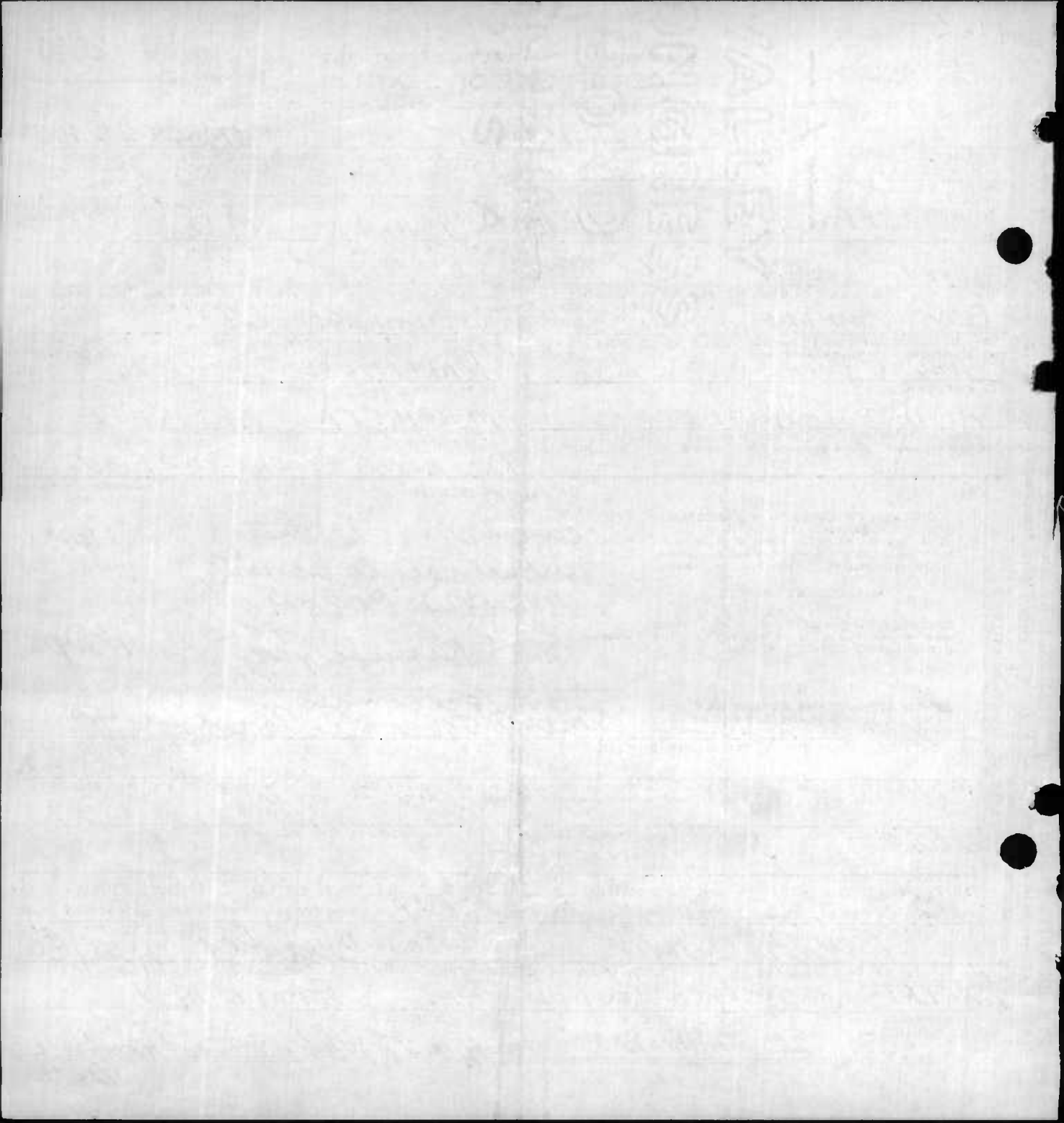
Wilmington, Delaware

Wm. S. A. Rohde 3327 Edmondson

VS 150

4813











UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

Letter in document file 50-2841 4/5/50.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

200  
50 2842

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2842

1. NAME OF DECEASED (Type or Print) <u>Winston Ross</u>			2. DATE OF DEATH <u>March 24/1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Med City</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>7-04</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>			D. STREET ADDRESS (If rural, give location) <u>1027 Summit Ave.</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 5, 1922</u>	9. AGE (In years last birthday) <u>28</u>	If Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed laborer -</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) <u>Prince Edward Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Arthur Ross</u>			14. MOTHER'S MAIDEN NAME <u>Emma Willie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>219-01-9396</u>	17. INFORMANT ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		

18. <u>292.6</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH <u>Sickle Cell Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (A) ANTECEDENT CAUSES			DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>3-24</u>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>3-24</u> , 19 <u>50</u> to <u>3-24</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>50</u> , and that death occurred at <u>6:49</u> p.m., from the causes and on the date stated above.						
23A. SIGNATURE <u>William W. Wintermich</u>		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>Mar 25 1950</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>March 28/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>A. A. County Md.</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 27 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. Wintermich</u>	25. FUNERAL DIRECTOR <u>Mr. Arthur A. Elliser, Daugherty</u>		ADDRESS <u>735 11297. Caroline St.</u>		



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

542  
50 2843

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2843

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Robert Daniels</u>		2. DATE OF DEATH <u>March 25, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>18-02</u>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>P. O. Carey St.</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-20-09</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sign Painter Co. Co. BEVERLY</u>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <u>40</u>
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>George Daniels</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Lena Daniels</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u>		ADDRESS _____	

MEDICAL CERTIFICATION	18. <u>162X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>CARCINOMA, BRONCHOGENIC 2 YEARS</u> DUE TO <u>LEFT LUNG, WITH</u> <u>METASTASES TO RIGHT</u> (B) <u>CEREBRAL HEMISPHERE</u> DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH _____
-----------------------	--	--	--

19A. DATE OF OPERATION <u>JULY 26, 1948</u>		19B. MAJOR FINDINGS OF OPERATION <u>METASTATIC CA, RT. CEREBRAL HEMISPHERE</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>3-25</u> , 19 <u>50</u> , to <u>3-25</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>50</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.				
23A. SIGNATURE <u>Robert E. Green</u> M. D.		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>Mar 26, 1950</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>March 28, 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenville N.C.</u>
24D. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR ADDRESS <u>Mrs. P. G. Elliott &amp; Daughter</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 27 1950</u>		REGISTRAR'S SIGNATURE <u>Thurston Williams</u>		

VS 150

340X0

47c 1129 N. Caroline St.



CERTIFICATE OF DEATH

THE TOWN OF NEWTON, MASSACHUSETTS

Attest, I, the undersigned, being a Justice of the Peace for the County of Middlesex, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the Town of Newton, Massachusetts, in the year of our Lord one thousand nine hundred and twenty-two.

Witness my hand and the seal of said County, at the City of Boston, this 1st day of January, 1923.

Notary Public for the County of Middlesex, Massachusetts.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

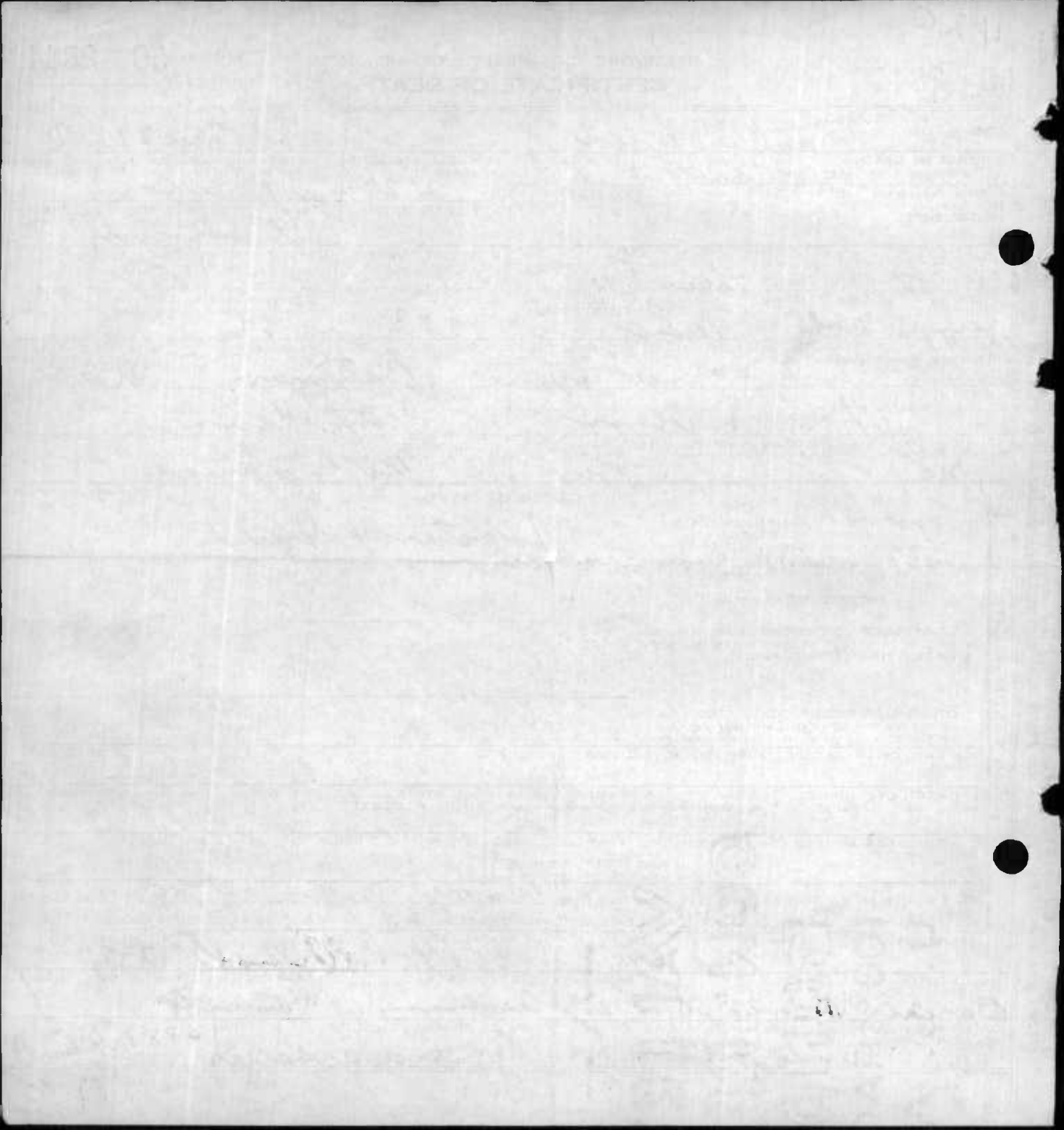
50 2844  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Lottie J. Willis</i>		2. DATE OF DEATH <i>Mar 24, 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto City Md</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>2027 Union H. Ave</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore City</i>	
c. Length of stay in Baltimore <i>Life time</i>		D. STREET ADDRESS (If rural, give location) <i>14-03</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>1883</i>
9. AGE (In years last birthday) <i>67</i>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Albert Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Elinor Kane</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mable Johnson</i>		ADDRESS	

18. <i>760 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Diabetes + Senility</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO		
19A. DATE OF OPERATION <i>6</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Mar 21, 1950</i> , to <i>Mar 23, 1950</i> that I last saw the deceased alive on <i>Mar 20, 1950</i> , and that death occurred at <i>5 a.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>W. B. Scott</i>	23B. ADDRESS <i>354 N. Baltimore</i>	23C. DATE SIGNED <i>3-27-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Mar 28-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Wm. A. Arthur</i>
24D. LOCATION (City, town, or county) (State) <i>Balto</i>	25. FUNERAL DIRECTOR <i>James G. Stays</i>	ADDRESS <i>638 N. Julian</i>







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2845

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HARRY HALL

2. DATE

OF DEATH

March 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

Maryland General Hospital

C. Length of stay in Baltimore

Life

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Nov. 24/1892 58

9. AGE (In years

last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work attended during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

CAB DRIVER

13. FATHER'S NAME

Unknown

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes W.W.#1

16. SOCIAL SECURITY NO.

17. INFORMANT

Katie Wilson - Jenkins

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of Stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Ryan

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Baltimore National Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

Stuntington Williams, M.D.

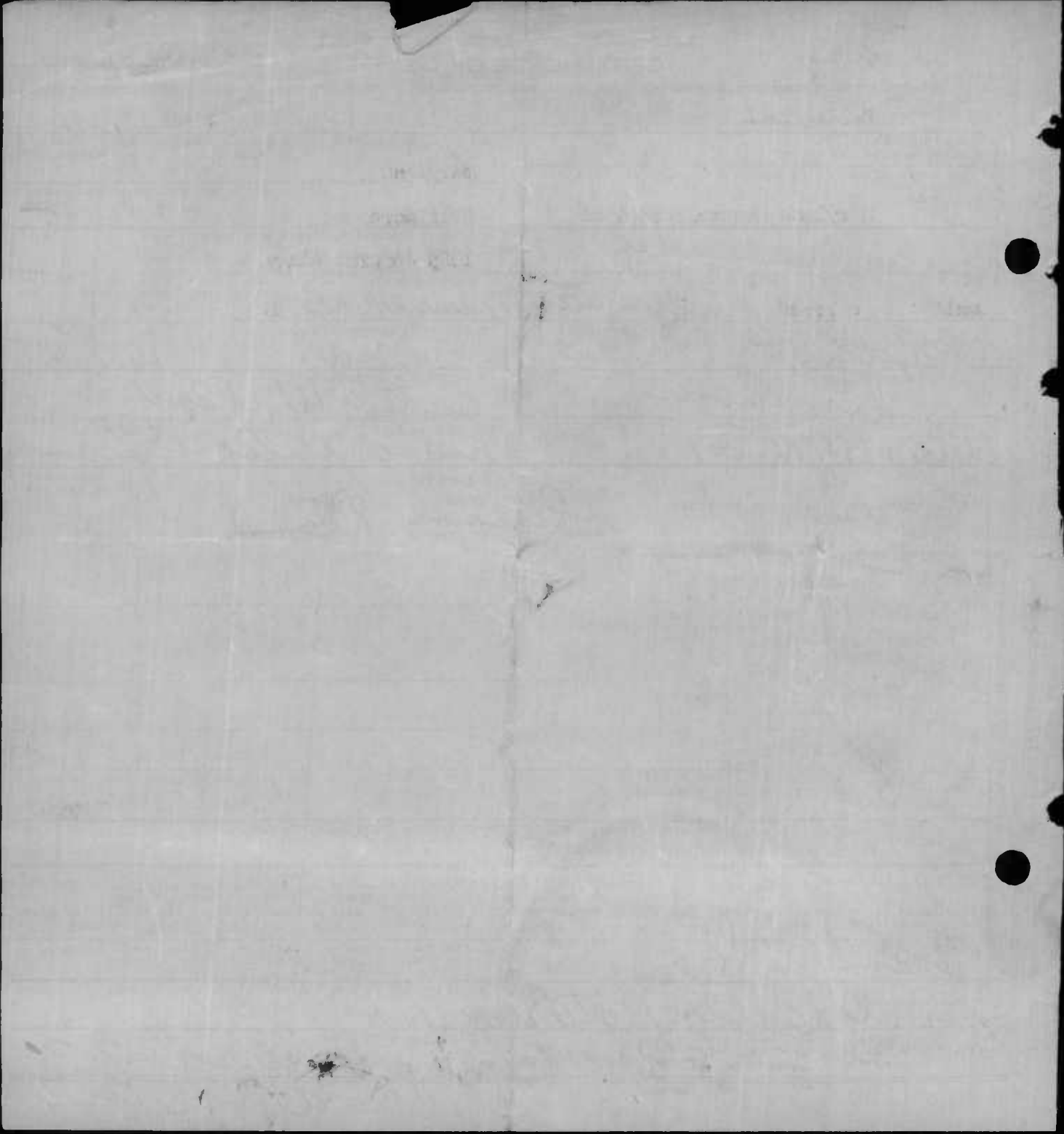
25. FUNERAL DIRECTOR

ADDRESS

218 S. Guilford St. - 918-4612

4205V David Hall







P-264

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2846  
Registered No.

BIRTH NO. 50 2846

1. NAME OF DECEASED (Type or Print) <b>Anthony Pasquariello</b>			2. DATE OF DEATH <b>March 24 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>505 Albemarle</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Carle St.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>505 Albemarle St.</b>			3-02		
c. Length of stay in Baltimore Yrs. Mos. Days					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>November 5 1869</b>	9. AGE (in years: last birthday) <b>80</b>	10. Under 1 Year Months: Days Hours Min. <b>4 19</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor (Retired)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>		
11. BIRTHPLACE (State or foreign country) <b>Fontana Rosa Italy</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Generoso Pasquariello</b>			14. MOTHER'S MAIDEN NAME <b>Pasqua ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Anna Bruni 296 Spring Ct.</b>		

18. <b>4 yr. r</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Apoplexy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cerebral arterio-sclerosis</b>		<b>?</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic Myocarditis</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>March 6, 1950</b> , to <b>March 24, 1950</b> , that I last saw the deceased alive on <b>March 24, 1950</b> , and that death occurred at <b>4:15 p. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>James J. Temple</b>		23B. ADDRESS <b>300 E. Pratt St.</b>		23C. DATE SIGNED <b>3/25/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 28 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Balt. Md.</b>		DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>			
REGISTRAR'S SIGNATURE <b>Amington Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>Frank D. DeLoach 322 S. High St.</b>			



VALLEY

BOARD

OF

COMMISSIONERS

OF

THE

LANDS

OF

THE

STATE

OF

NEW

YORK

1880



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2847

BIRTH NO. 50 2847

1. NAME OF DECEASED  
(Type or Print)

Elizabeth Michie Hildreth

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

14-01

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1517 Bolton St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

DEC. 21, 1900

9. AGE (In years  
last birthday)

49

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CLERICAL

10B. KIND OF BUSINESS OR  
INDUSTRY

REAL ESTATE

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

GEORGE R. B. MICHIE

14. MOTHER'S MAIDEN NAME

HADEE WATSON PERKINS ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-18-4491

17. INFORMANT

ADDRESS

MRS. A. L. HENCH CHARLOTTESVILLE VA

18. E972

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Incised wounds of wrists, bilateral

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1517 Bolton St.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

March 26, 1950 abt. 5 p.m.

21E. INJURY OCCURRED

WHILE AT ☐

NOT WHILE ☒  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Gas stove on but unlit, Sharp instrument

O.C.-  
(Heating type)

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

*B. Fisher*

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

March 27, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

3-28-1950

24C. NAME OF CEMETERY OR CREMATORY

RIVERVIEW

24D. LOCATION (City, town, or county) (State)

CHARLOTTESVILLE VA.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wm. Williams*

25. FUNERAL DIRECTOR

ADDRESS

H. B. JENKINS & Son Co. 4905 YORK RD.

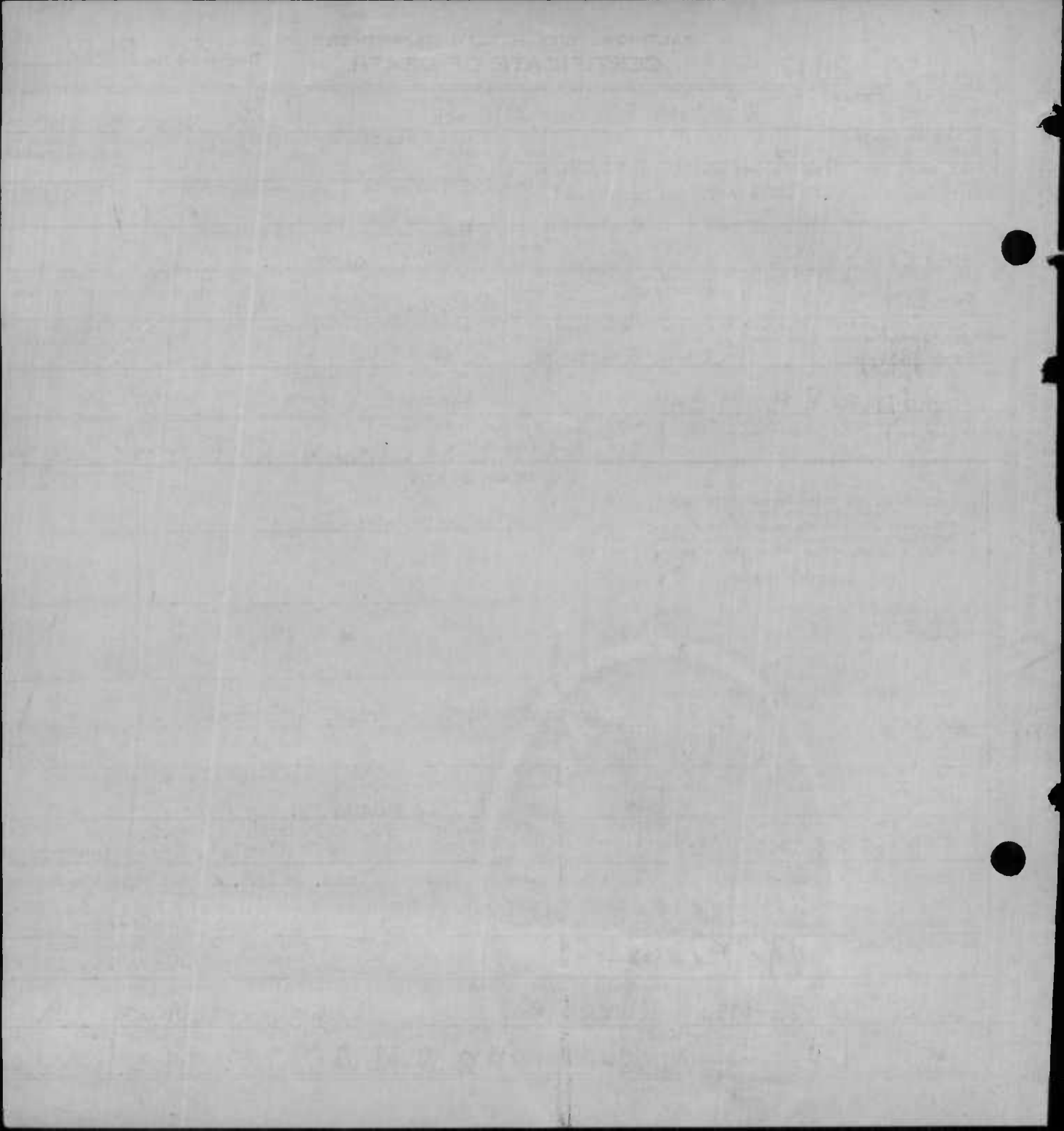
VS 151

N-968

26681

163H







Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important. WITH UNFADING INK. correct age is especially important.

536  
50 2848

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2848

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

KATE S. ANDERSON.

2. DATE OF DEATH *March-25-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *419-HAZLETT-AVE.*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE *Maryland.*  
B. COUNTY *Baltimore.*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 25-01a*

C. Length of stay in Baltimore *80 yrs.*

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)  
*419-Hazlett-Ave.*

5. SEX

*Female*

6. COLOR OR RACE

*White.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*Nov. 30-1866*

9. AGE (In years, last birthday)

*83 yrs.*

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife.*

10B. KIND OF BUSINESS OR INDUSTRY

*Own Home.*

11. BIRTHPLACE (State or foreign country)

*Wheeling - W. Va.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Wm. H. Silwright.*

14. MOTHER'S MAIDEN NAME

*Mary G. McKee.*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*no.*

16. SOCIAL SECURITY NO.

*none.*

17. INFORMANT ADDRESS

*Miss Ethel G. Anderson - 419-Hazlett Ave.*

18. *422.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Pneumonia Terminal*

INTERVAL BETWEEN ONSET AND DEATH  
*2 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

*Hypertension*

(B)

*Cardio-Vascular*

DUE TO

*Arteriosclerosis*

(C)

*Grade III*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *6/27*, 19*50*, to *3/25*, 19*50*, that I last saw the deceased alive on *3/25*, 19*50*, and that death occurred at *8:10 P.M.*, from the causes and on the date stated above.

22. SIGNATURE

*Eliot W. Johnson*

M. D.

23B. ADDRESS

*3432 Fredrick Ave*

23C. DATE SIGNED

*3/27/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Burial*

*March 28-1950*

*Lorraine Park Cemetery*

*Md.*

*MAR 27 1950*

*Timothy H. Antiqua*

*Charles J. Schwalb*

*-3512-Fredrick Ave.*



8:10 P.M.







1202 71 Caroline St



correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2850

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LOLA

QUINN

2. DATE  
OF  
DEATH

March 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

228 N. High Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

MARCH 17, 1899

9. AGE (In years  
last birthday)

53

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Intra cranial Hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cirrhosis of liver  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. McCafferty

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

3-27-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/28/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

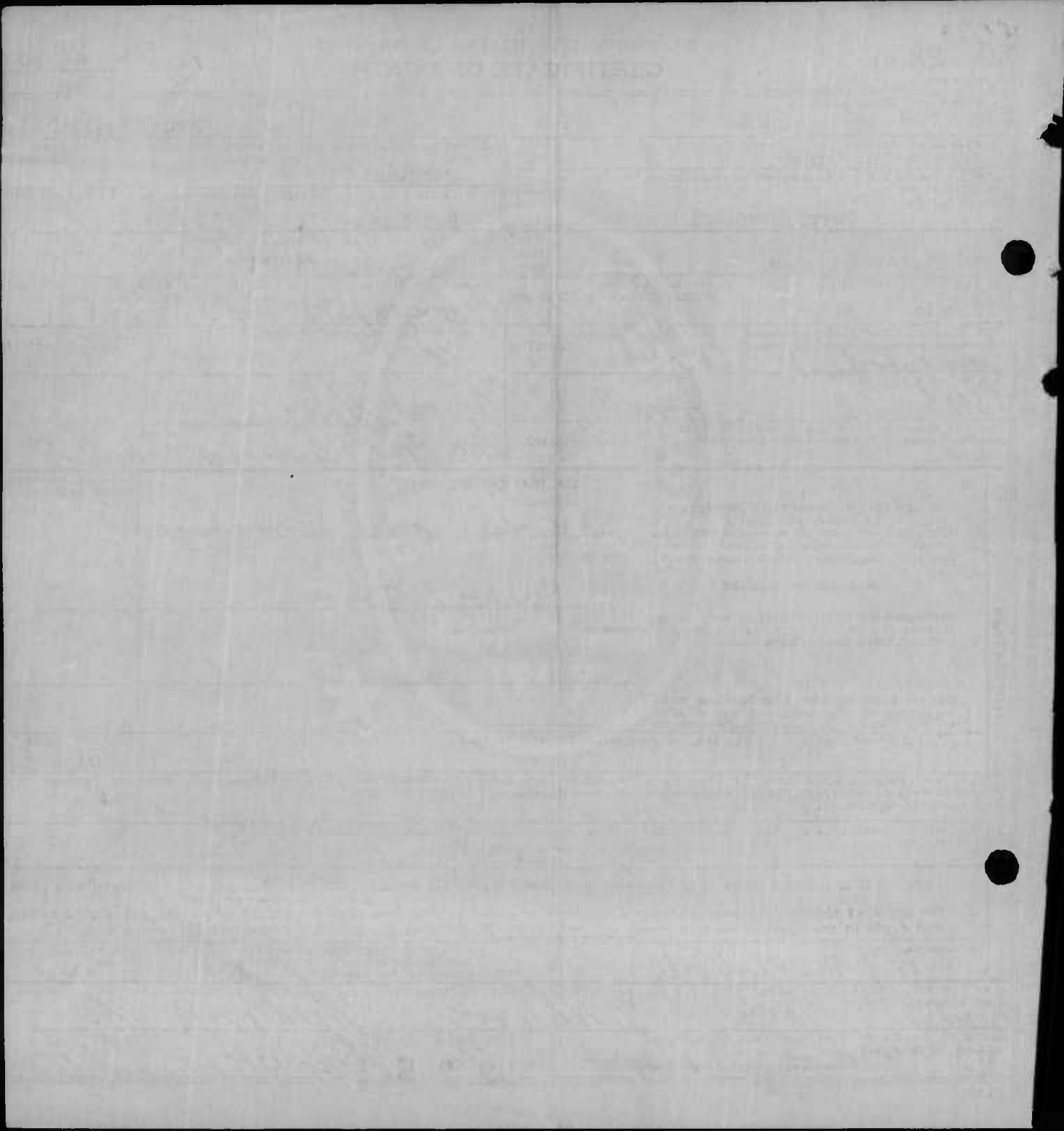
Mar 27 1950 Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1217 H. Paul St







W-100  
The information on this form should be carefully supplied. Every item of information should be clearly and legibly written. Physicians: please write the causes of death clearly and legibly. This form is especially important.

50 2851

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2851  
Registered No.

1. NAME OF DECEASED  
(Type or Print)

Charles M. Webb

2. DATE  
OF  
DEATH

3-24-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1083 W Fayette St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

18-02

D. STREET ADDRESS (If rural, give location)

1083 W Fayette St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 11, 1911

9. AGE (in years  
last birthday)

39

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR  
INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A. ✓

13. FATHER'S NAME

Jefferson Webb

14. MOTHER'S MAIDEN NAME

Maggie Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, never unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Grace Mills

ADDRESS 2658  
Flora St.

18. 490x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

DUE TO

Lobar Pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

DUE TO

(C) ...

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4 1950 to 3/24 1950, that I last saw the  
deceased alive on 3/24 1950, and that death occurred at 11:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Ralph W. Neikley, Jr.

23B. ADDRESS

4211 N. Glen St.

23C. DATE SIGNED

3/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3-28-1950

24C. NAME OF CEMETERY OR CREMATORY

St. Paulin Cemetery

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Hollingsworth

25. FUNERAL DIRECTOR

Williams N. Schorady, Jr.

ADDRESS

322

MAR 27 1950

VS 150

42086

108







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2852  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ida Ivory Staples

2. DATE  
OF  
DEATH March 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

20-01

D. STREET ADDRESS (If rural, give location)

1910 W. Lexington St.

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

Domestic

INDUSTRY

Balto. Md.

USA

13. FATHER'S NAME

Robert Staples

14. MOTHER'S MAIDEN NAME

Alice Commett

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

No

Alice Staples 1910 W. Lex. St.

1B.

331X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Hemorrhage  
DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arterial Hypertension  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

B. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED  
March 25, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR  
MAR 27 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Age at Death		Sex	
Cause of Death		Occupation	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	



N-252  
50 2853

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2853  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles H. Washington.

2. DATE OF DEATH

March 23, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

949 W. Franklin St.

C. Length of stay in Baltimore

Life

5. SEX

male

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labourer

10B. KIND OF BUSINESS OR INDUSTRY

General

13. FATHER'S NAME

Charles H. Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Annie Wells. 949 W. Franklin St.

ADDRESS

18. 491

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Left Pneumonia

Week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Capillary Bronchitis

2 weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

4 of pneumonia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/9/50 to 3/13/50, that I last saw the deceased alive on 3/13/50, and that death occurred at A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 27 1950

Washington, D.C.

25. FUNERAL DIRECTOR ADDRESS

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

IN SENATE  
January 11, 1911  
REPORT OF THE  
COMMISSIONER OF HEALTH  
ON THE  
ANNUAL REPORT OF THE  
COMMISSIONER OF HEALTH  
FOR THE YEAR 1910

ALBANY:  
J. B. LIPPINCOTT & CO.  
1911

PRINTED BY  
J. B. LIPPINCOTT & CO.  
ALBANY, N. Y.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2854

Registered No. \_\_\_\_\_

120  
50 2854

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <i>Maryalice Johnson Davis</i>			2. DATE OF DEATH <i>3-22-50</i>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>509 S. Green St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY _____						
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>since birth</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Balto</i> <i>22-02</i>						
C. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>509 S. Green St</i>						
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cal</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH <i>1-28-22</i>		9. AGE (In years last birthday) <i>28</i>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>factory worker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>TIN CAN CANNING CO.</i>			11. BIRTHPLACE (State or foreign country) <i>Balto, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S</i>	
13. FATHER'S NAME <i>Louis Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Mary Carnish</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>0</i>			16. SOCIAL SECURITY NO. <i>0</i>			17. INFORMANT ADDRESS <i>mother</i>			

18. <i>490X</i> <i>002X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Labar Pneumonia</i>		<i>3 days Probably 4 to 5 days</i>	
ANTECEDENT CAUSES		(B) <i>exposure, etc etc</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <i>(over)</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *3-20-50*, to *3-22-50*, that I last saw the deceased alive on *3-22-50*, and that death occurred at *4 P* m., from the causes and on the date stated above.

23A. SIGNATURE <i>F. N. Cardoso</i>	M. D.	23B. ADDRESS <i>1524 Druid Avenue</i>	23C. DATE SIGNED <i>3-23-50</i>
--	-------	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-27-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem. Balto Md</i>	24D. LOCATION (City, town, or county) (State) <i>Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 27 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. J. Holloman</i>	25. FUNERAL DIRECTOR <i>Mrs. Kate G. Williams</i>	
		ADDRESS <i>322 N Schreder</i>	

MEDICAL CERTIFICATION

Physicians: please write the causes of death clearly and legibly.



Diagnosed as Pul. TBC. University, & BC Hospitals  
See Document File 50-2854

6.26.50 Es



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert E. Wiley

2. DATE  
OF  
DEATH

3-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

606 S. Patterson Park Ave

C. Length of stay in Baltimore

Life

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Pipe Fitter

10B. KIND OF BUSINESS OR  
INDUSTRY

Gas &amp; Elec. Co.

13. FATHER'S NAME

Thomas Wiley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Ind.

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write HURAI, and give  
township)

Baltimore - Ind

D. STREET ADDRESS (If rural, give location)

606 S. Patterson Park Ave

8. DATE OF BIRTH

May 28-1885

9. AGE (In years  
last birthday)

64

If Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Balto - Ind.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Mary Nitzel

17. INFORMANT

ADDRESS

Catherine Wiley-606 Patterson Park Ave

18. 592 x I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Chronic myocarditis

1949

DUE TO

Chronic nephritis  
(Pulmonary Edema)

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK22. I hereby certify that I attended the deceased from Sept. 1949, to Mar 26, 1950, that I last saw the  
deceased alive on Mar 26, 1950, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Geo. S. Leptin

M. O.

23B. ADDRESS

426 S. Patterson Park Ave

23C. DATE SIGNED

3/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3-30-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Carmel

24D. LOCATION (City, town, or county)

Balto - Ind

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams

25. FUNERAL DIRECTOR

ADDRESS

2225 E. Zeeb - 403 S. Wolf St

VS 150

34859

131a



En. Lippay



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2856

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Margaret May McGreevy</b>		2. DATE OF DEATH <b>March 25, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>Unknown</b>		D. STREET ADDRESS (If rural, give location) <b>34 S. Decker Ave.,</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6/30/1886</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hwfe.</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>63</b>	11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Maryland</b>
13. FATHER'S NAME <b>Phillip Lawrence</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	14. MOTHER'S MAIDEN NAME <b>Amy Martin</b>	
17. INFORMANT <b>Mrs. Lawrence Kries</b>		ADDRESS <b>34 S. Decker Ave Balto.</b>	

18. <b>174X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of uterus</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Carcinoma of uterus &amp; intestines</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>3</b>	19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of uterus</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2/26/50**, 19**50**, to **3/25/**, 19**50**, that I last saw the deceased alive on **3/25/**, 19**50**, and that death occurred at **6:10 A.M.** from the causes and on the date stated above.

23A. SIGNATURE <b>[Signature]</b>	23B. ADDRESS <b>400 N. Caroline Street</b>	23C. DATE SIGNED <b>3/25/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/28/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Josephs</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	24D. LOCATION (City, town, or county) (State) <b>Emmitsburg Md.</b>
25. FUNERAL DIRECTOR <b>Lilly &amp; Geiler Inc.</b>		ADDRESS <b>403 S. Wolfe St. Balto.</b>

48B



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Manner of death		8. Signature of physician		9. Signature of registrar		10. Date of registration	
11. Name of informant		12. Address of informant		13. Signature of informant		14. Signature of witness		15. Date of completion	



460

50 2857

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2857

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH W. TAYLOR

2. DATE  
OF  
DEATH

3-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

519 S. PONCA ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 26-05

D. STREET ADDRESS (If rural, give location)

519 S. PONCA ST.

c. Length of stay in Baltimore

?

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

2-12-1891

9. AGE (In years last birthday)

59

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

WATCHMAN

10B. KIND OF BUSINESS OR INDUSTRY

BALTO. CITY

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL SECURITY NO.

?

17. INFORMANT

CATHERINE TAYLOR

ADDRESS

SAME

18. 420 1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Crowning Thrombus

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March, 1949, to March, 1950, that I last saw the deceased alive on March 27, 1950, and that death occurred at 1 Ann., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Spelman

23B. ADDRESS

3400 E. Balto

23C. DATE SIGNED

3/27/50

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

3/28/50

24C. NAME OF CEMETERY OR CREMATORY

BALTO. NATIONAL

24D. LOCATION (City, town, or county) (State)

BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Wally S. Zeiler INC. BALTO.

ADDRESS

BALTO.

VS 150

602 98

94a

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Goodman

3400 E. Balto.

(Br. 1764)



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2858

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

DOROTHY

RICHARDSON

2. DATE  
OF  
DEATH

March 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 14-02

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION  
507 Wilson Street

D. STREET ADDRESS (If rural, give location)  
507 Wilson Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 6, 1904

9. AGE (In years last birthday)

45

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maid

10B. KIND OF BUSINESS OR INDUSTRY

Private

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
U. S. A

13. FATHER'S NAME

William Richardson

14. MOTHER'S MAIDEN NAME

Addie Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS 3408

Mrs. Addie Richardson- Auchentoroly

18. 420.0

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED  
3-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-28-50

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county)

Baltimore CO., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Mrs. Frances A. Hemsley

ADDRESS

578 W. Biddle St.



REPORT OF THE

1951

1951		1952		1953		1954		1955		1956		1957		1958		1959		1960		1961		1962		1963		1964		1965		1966		1967		1968		1969		1970		1971		1972		1973		1974		1975		1976		1977		1978		1979		1980		1981		1982		1983		1984		1985		1986		1987		1988		1989		1990		1991		1992		1993		1994		1995		1996		1997		1998		1999		2000		2001		2002		2003		2004		2005		2006		2007		2008		2009		2010		2011		2012		2013		2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024		2025		2026		2027		2028		2029		2030		2031		2032		2033		2034		2035		2036		2037		2038		2039		2040		2041		2042		2043		2044		2045		2046		2047		2048		2049		2050		2051		2052		2053		2054		2055		2056		2057		2058		2059		2060		2061		2062		2063		2064		2065		2066		2067		2068		2069		2070		2071		2072		2073		2074		2075		2076		2077		2078		2079		2080		2081		2082		2083		2084		2085		2086		2087		2088		2089		2090		2091		2092		2093		2094		2095		2096		2097		2098		2099		2100		2101		2102		2103		2104		2105		2106		2107		2108		2109		2110		2111		2112		2113		2114		2115		2116		2117		2118		2119		2120		2121		2122		2123		2124		2125		2126		2127		2128		2129		2130		2131		2132		2133		2134		2135		2136		2137		2138		2139		2140		2141		2142		2143		2144		2145		2146		2147		2148		2149		2150		2151		2152		2153		2154		2155		2156		2157		2158		2159		2160		2161		2162		2163		2164		2165		2166		2167		2168		2169		2170		2171		2172		2173		2174		2175		2176		2177		2178		2179		2180		2181		2182		2183		2184		2185		2186		2187		2188		2189		2190		2191		2192		2193		2194		2195		2196		2197		2198		2199		2200		2201		2202		2203		2204		2205		2206		2207		2208		2209		2210		2211		2212		2213		2214		2215		2216		2217		2218		2219		2220		2221		2222		2223		2224		2225		2226		2227		2228		2229		2230		2231		2232		2233		2234		2235		2236		2237		2238		2239		2240		2241		2242		2243		2244		2245		2246		2247		2248		2249		2250		2251		2252		2253		2254		2255		2256		2257		2258		2259		2260		2261		2262		2263		2264		2265		2266		2267		2268		2269		2270		2271		2272		2273		2274		2275		2276		2277		2278		2279		2280		2281		2282		2283		2284		2285		2286		2287		2288		2289		2290		2291		2292		2293		2294		2295		2296		2297		2298		2299		2300		2301		2302		2303		2304		2305		2306		2307		2308		2309		2310		2311		2312		2313		2314		2315		2316		2317		2318		2319		2320		2321		2322		2323		2324		2325		2326		2327		2328		2329		2330		2331		2332		2333		2334		2335		2336		2337		2338		2339		2340		2341		2342		2343		2344		2345		2346		2347		2348		2349		2350		2351		2352		2353		2354		2355		2356		2357		2358		2359		2360		2361		2362		2363		2364		2365		2366		2367		2368		2369		2370		2371		2372		2373		2374		2375		2376		2377		2378		2379		2380		2381		2382		2383		2384		2385		2386		2387		2388		2389		2390		2391		2392		2393		2394		2395		2396		2397		2398		2399		2400		2401		2402		2403		2404		2405	
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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2859  
Registered No.50 2859  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mildred Hammond Bowerman</b>			2. DATE OF DEATH <b>March 26, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>none</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2405 Maryland Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>12-06</b>		
c. Length of stay in Baltimore <b>life</b>			D. STREET ADDRESS (If rural, give location) <b>2405 Maryland Ave.</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Nov 14, 1867</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>proprietress</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>hotel-retired 20 yrs</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Gen. Richard Neville Bowerman</b>			14. MOTHER'S MAIDEN NAME <b>Eliza</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mrs. Mary R. Denton - 2101 St. Paul St.</b>			ADDRESS		

18. <b>490x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia, lobar, left lower</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>								
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Uremia.</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>								
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Jan</b> , 1949, to <b>March 26</b> , 1950, that I last saw the deceased alive on <b>March 25, 1950</b> , and that death occurred at <b>7:30 Am.</b> , from the causes and on the date stated above.								
23A. SIGNATURE <b>E. E. Smith</b> M. D.			23B. ADDRESS <b>2431 MARYLAND AVE</b>			23C. DATE SIGNED <b>3/26/50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			24B. DATE <b>3 - 28 - 50</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			24E. FUNERAL DIRECTOR <b>John O. Mitchell &amp; Sons, Inc.</b>			24F. ADDRESS <b>-1900 Eutaw Pl.</b>		

MAR 27 1950  
VS 150

108



STATE OF TEXAS

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# CERTIFICATE CORRECTED

4-3-50

BALTIMORE CITY HEALTH DEPARTMENT

50 2860

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Moore, Mr. Thomas Howard

2. DATE  
OF  
DEATH

MARCH 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Home for Incurables - 700 W. 40<sup>th</sup> ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

15-07B

D. STREET ADDRESS (If rural, give location)

2309 Ellamont St.

c. Length of stay in Baltimore

62 yrs.

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Feb. 17, 1863

9. AGE (In years last birthday)

86

If Under 1 Year Months: Days

If Under 24 Hours Hours Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired B. & O. Fuel Agt.

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Moore

14. MOTHER'S MAIDEN NAME

MARY E. STRATTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO. NO

17. INFORMANT ADDRESS

S. E. Ross - 700 W. 40<sup>th</sup> ST.

18. 443X

### CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic • Hypertensive Cardiovascular Disease with right hemiplegia

INTERVAL BETWEEN ONSET AND DEATH

10 years ±

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Recurring attacks Bronchial Pneumonia

4 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov. 23<sup>rd</sup>, 1948, to March 25<sup>th</sup>, 1950, that I last saw the deceased alive on March 25, 1950, and that death occurred at 5:05 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas Conrad W. H. J.

23B. ADDRESS

11 E. Chase St. Baltimore 2, Md.

23C. DATE SIGNED

3/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/28/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 27 1950

REGISTRAR'S SIGNATURE

Thurston H. H. J.

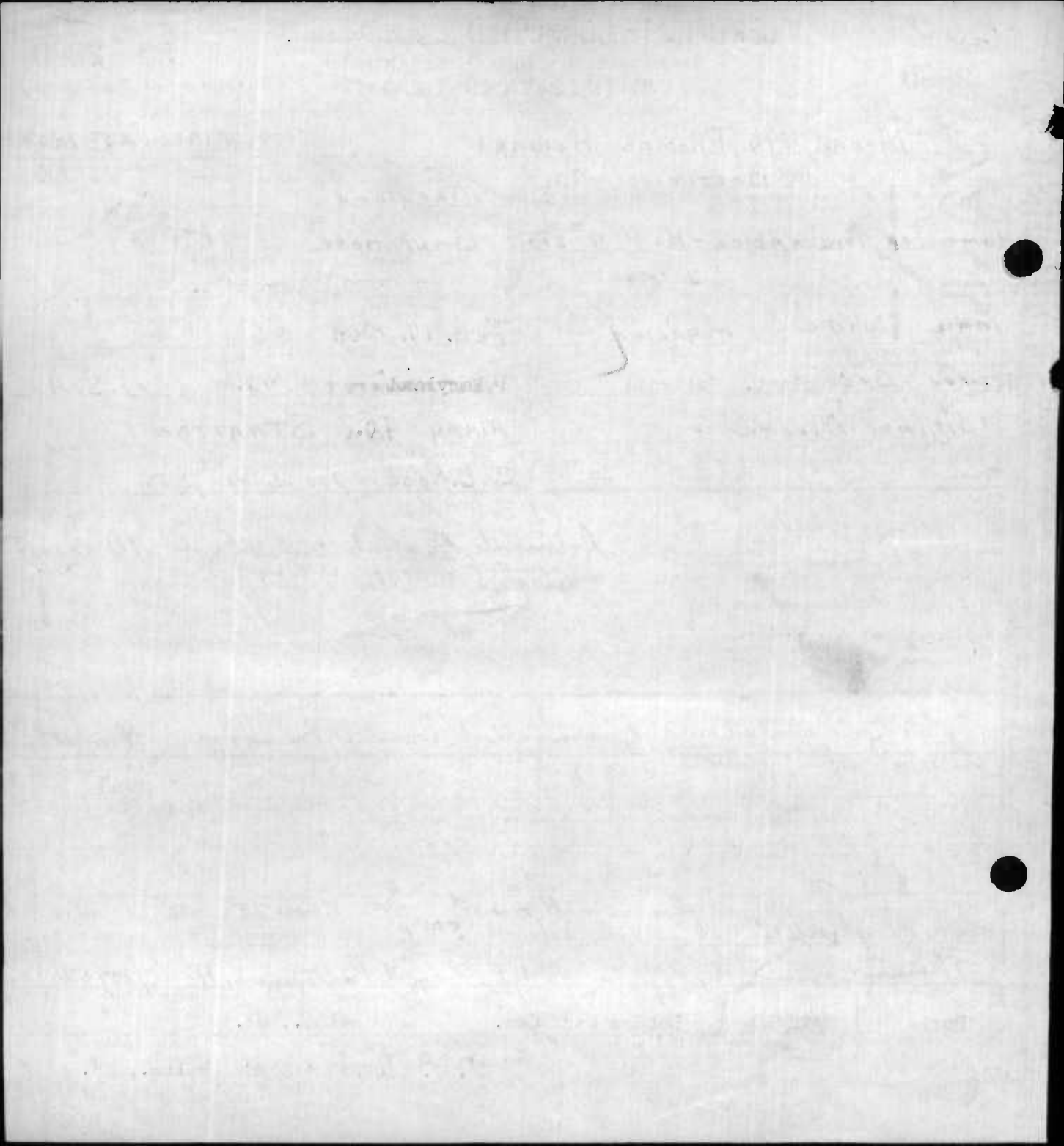
25. FUNERAL DIRECTOR

W. J. T. KENNER & SONS

ADDRESS

Balto., Md.







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 2861

50 2861

BIRTH NO. \_\_\_\_\_

<b>1. NAME OF DECEASED</b> (Type or Print) <i>George Ashby Burton</i>		<b>2. DATE OF DEATH</b> <i>3-27-50</i>	
<b>3. PLACE OF DEATH:</b> <b>A. Baltimore City, Maryland</b> <b>B. FULL NAME OF (If not in hospital or institution, give street address or location)</b> <i>Union Memorial Hospital</i>		<b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b> <b>A. STATE</b> <i>Maryland</i> <b>B. COUNTY</b> <i>Montgomery</i> <b>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)</b> <i>Bartonsville</i> <b>D. STREET ADDRESS (If rural, give location)</b>	
<b>5. SEX</b> <i>Male</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <i>Married</i>		<b>8. DATE OF BIRTH</b> <i>Oct 20, 1882</i> <b>9. AGE (In years last birthday)</b> <i>67</i>	
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <i>Farmer</i> <b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <i>Maryland</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>George Burton</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Emma</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)</b> <i>Unknown</i> <b>16. SOCIAL SECURITY NO.</b> <input checked="" type="checkbox"/>		<b>17. INFORMANT ADDRESS</b> <i>Patient</i>	

<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <i>Multiple Cerebral Emboli</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Chronic Auricular Fibrillation</i> DUE TO (C) <i>Old Rheumatic Heart Disease</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension and Arteriosclerotic Sclerosis</i>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>3 days</i>	
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<b>19A. DATE OF OPERATION</b> <i>3-20-50</i> <b>19B. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)</b>	<b>21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)</b>	<b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b>	
<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>	<b>21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></b>	<b>21F. HOW DID INJURY OCCUR?</b>	

<b>22. I hereby certify that I attended the deceased from</b> <i>3-20</i> , 19 <i>50</i> , <b>to</b> <i>3-27</i> , 19 <i>50</i> , <b>that I last saw the deceased alive on</b> <i>3-26</i> , 19 <i>50</i> , <b>and that death occurred at</b> <i>12 52</i> m., <b>from the causes and on the date stated above.</b>			
<b>23A. SIGNATURE</b> <i>Henry Charles Shaffer</i> M. D.		<b>23B. ADDRESS</b> <i>Union Memorial Hospital</i>	
<b>23C. DATE SIGNED</b> <i>3-27-50</i>		<b>24. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Rural</i>	
<b>24B. DATE</b> <i>3-29-50</i>	<b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Union</i>	<b>24D. LOCATION (City, town, or county)</b> <i>Bartonsville Md</i>	<b>24E. STATE</b> <i>Md</i>
<b>25. FUNERAL DIRECTOR ADDRESS</b> <i>Huntington Williams</i>		<b>25. FUNERAL DIRECTOR ADDRESS</b> <i>Howard Qualbeck, Laurel Md</i>	

MAR 27 1950 VS 150

000VV

95B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



MINNESOTA  
CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2862

Registered No. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Gilbert Sackerman**

2. DATE  
OF  
DEATH

**March 27, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION  
**Colonial Nursing Home**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**610 Cathedral St.**

E. Length of stay in Baltimore

**Life**

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Widowed**

8. DATE OF BIRTH

**Sept. 3, 1876**

9. AGE (In years last birthday)  
**73 28 75**

If Under 1 Year  
Months Days Hours Min.  
**6 24**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Artist**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
**Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Gabriel Sackerman**

14. MOTHER'S MAIDEN NAME

**Emma Coblens**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
**No**

16. SOCIAL SECURITY NO.

17. INFORMANT  
**Mr. Walter Sackerman Cathedral St.**

18. **422.1**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Arteriosclerotic Cardio-**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

**Vascular Disease**

DUE TO

(C)

**syn**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6-10-47**, 19**47**, to **3-28**, 19**50**, that I last saw the deceased alive on **3-27**, 19**50**, and that death occurred at **5:30 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE

**P. D. Tyner**

M. O.

23B. ADDRESS

**11 E. Clowck**

23C. DATE SIGNED

**3/28/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Mar. 28, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Baltimore Hebrew Cem.**

24D. LOCATION (City, town, or county) (State)

**Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR

**MAR 27 1950**

REGISTRAR'S SIGNATURE

**Thurston M. Williams, M.D.**

25. FUNERAL DIRECTOR

**David Sondheim & Son 1902 Eutaw Pl.**

ADDRESS

**David Sondheim & Son 1902 Eutaw Pl.**







650 50 2863

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2863  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sam

Green

2. DATE  
OF DEATH March 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Baltimore City Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore

26-12

No Home Address

Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Unknown

9. AGE (in years  
last birthday)

75 P

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Unknown

ADDRESS

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Arteriosclerotic cardio-

DUE TO

vascular disease

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

11

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inc. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

March 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



CERTIFICATE OF DEATH

STATE OF ILLINOIS

DECEASED



560  
50 2864

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2864

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

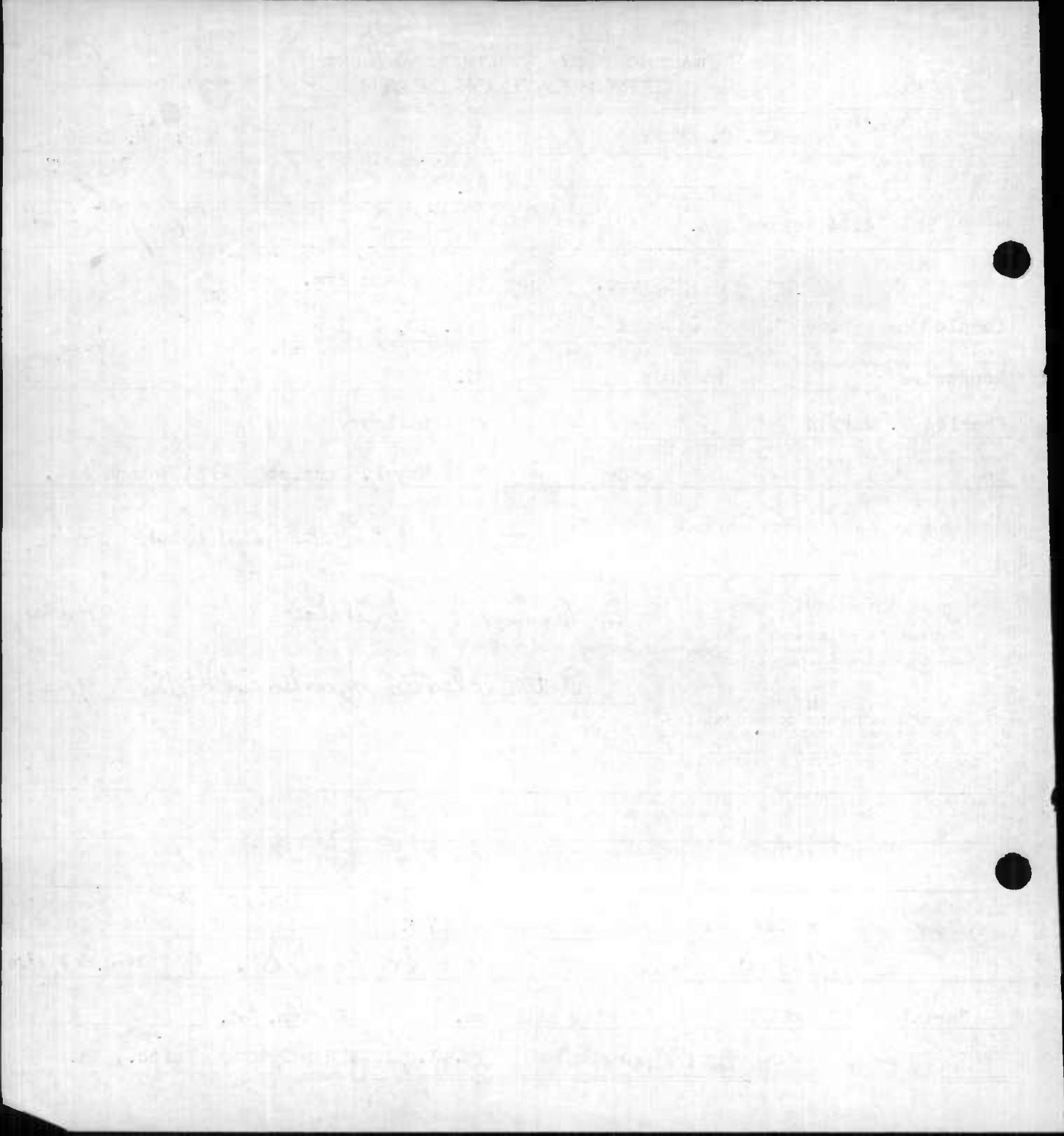
1. NAME OF DECEASED (Type or Print) <b>HELEN C. EMORY</b>		2. DATE OF DEATH <b>Mar. 25, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>4134 Roland Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>4134 Roland Ave.</b>		E. Length of stay in Baltimore <b>25 yrs.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Jan. 10, 1861</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9. AGE (In years last birthday) <b>89</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Charles G. Martin</b>		14. MOTHER'S MAIDEN NAME <b>Martina Lowry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Miss May P. Bartlett</b>		ADDRESS <b>4134 Roland Ave.</b>	

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Embolism (Pulmonary Cerebral)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arricular Fibrillation</b>		<b>4 wks.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic Hypertensive Ht. Dis.</b>		<b>Yrs.</b>
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>1946</b> , to <b>Mar 25, 1950</b> , that I last saw the deceased alive on <b>Mar. 24, 1950</b> , and that death occurred at <b>7 P. m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>Robert W. Garis</b>	23B. ADDRESS <b>1103 St. Paul St.</b>	23C. DATE SIGNED <b>Mar. 27, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/28/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cem.</b>
24D. LOCATION (City, town, or county) <b>Easton, Md.</b>		24E. FUNERAL DIRECTOR <b>WM. J. TICKNER &amp; SONS</b>
24F. ADDRESS <b>Balto., Md.</b>		

PLEASE WRITE IN FULL, correct age is especially important. Physicians please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2865  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William Uhl</b>		2. DATE OF DEATH <b>3-25-1950.</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>7-04</b>	
Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1819 E. Chase ST.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Dec. 3- 1857</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days <b>92 Yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jacob Uhl</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Fink</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Records B.C.H. 4940 Eastern Ave.</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Bronchiectasis</b>		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>9-9-</b> , 19 <b>44</b> , to <b>3-25-</b> , 19 <b>50</b> that I last saw the deceased alive on <b>3-25-</b> , 19 <b>50</b> , and that death occurred at <b>7.00 AM</b> from the causes and on the date stated above.				
23A. SIGNATURE <i>W. Rogers</i>		23B. ADDRESS <b>B.C.H. 4940 Eastern Ave.</b>		23C. DATE SIGNED <b>3-27-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Mar. 27, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 27 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>Henry Sander &amp; Sons Inc.</b> <b>Baltimore, Md.</b> <b>94a</b>	

PLEASE WRITE IN INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.







J-162  
50 2866BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2866  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS P. JEFFERSON</b>		2. DATE OF DEATH <b>MARCH 26, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2528 W. Lombard St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 20-04</b>	
D. STREET ADDRESS (If rural, give location) <b>2528 W. Lombard St.</b>		E. Length of stay in Baltimore <b>LIFE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>Jan. 27, 1891</b>
9. AGE (In years last birthday) <b>59</b>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Heating Appliances</b>	
13. FATHER'S NAME <b>John JEFFERSON</b>		14. MOTHER'S MAIDEN NAME <b>SALLY RUSE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-09-8394</b>	
17. INFORMANT <b>CARRIE OWENS</b>		ADDRESS <b>HYATTSVILLE, Md</b>	
18. <b>420.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion, 1 day</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>trauma</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>none</b> (C) <b>none</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/25</b> , 1950, to <b>3/26</b> , 1950, that I last saw the deceased alive on <b>3/25</b> , 1950, and that death occurred at <b>5:30 P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Henrietta Miller MD</b>		23B. ADDRESS <b>1030 Wilkens art</b>	
23C. DATE SIGNED <b>3/17/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MARCH 28, 1950</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel County Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Francis Gabe's Sons</b>	
25. FUNERAL DIRECTOR <b>Francis Gabe's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	

MAR 27 1950

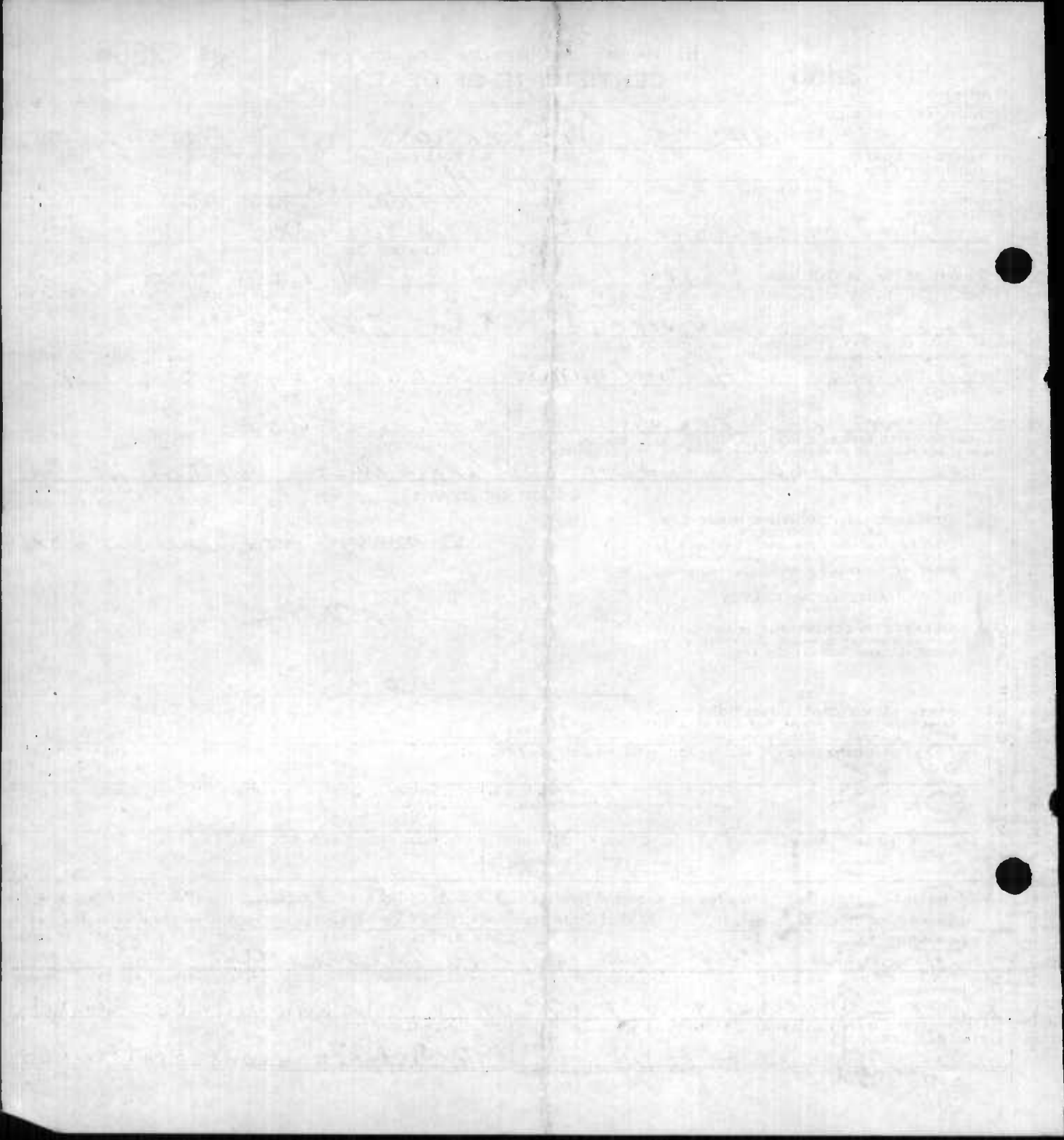
29860

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be written clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-455  
50 2867

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 2867  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Thomss Tillman Jr.

2. DATE  
OF  
DEATH

March 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Monkton

(Rural)

D. STREET ADDRESS (If rural, give location)

Janettsville Pike

Length of stay in Baltimore

years

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

5 JULY 1905

9. AGE (In years last birthday)

44

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

carpenter

10B. KIND OF BUSINESS OR INDUSTRY

CONST

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN T. TILLMAN

14. MOTHER'S MAIDEN NAME

BARBARA SNYDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

UNK

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

WIFE

ADDRESS

SAME

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ...

Posterior Myocardial Infarction

4 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

Coronary occlusion

4 hours

(C) ...

generalized arteriosclerosis

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 26, 1950, to March 27, 1950, that I last saw the deceased alive on March 27, 1950, and that death occurred at 11<sup>25</sup> A.m., from the causes and on the date stated above.

23A. SIGNATURE

Mr. F. Cox

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

3/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Mar 30 1950

24C. NAME OF CEMETERY OR CREMATORY

St. James

24D. LOCATION (City, town, or county)

Monkton, Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington, Delaware

25. FUNERAL DIRECTOR

Sanderson & Sons, Sparks, Md

ADDRESS

MAR 27 1950

VS 150

308V9

94a



STATE OF NEW YORK  
CERTIFICATE OF DEATH

FILE NO. 100-100000  
DATE OF DEATH 10-10-1910

NAME OF DECEASED JOHN J. BROWN  
AGE 45 YEARS  
SEX MALE  
RACE WHITE

PLACE OF BIRTH NEW YORK  
DATE OF BIRTH 10-10-1865  
OCCUPATION LABORER

CAUSE OF DEATH  
DISEASE

PLACE OF DEATH  
HOSPITAL

DATE OF DEATH 10-10-1910  
TIME OF DEATH 10:00 AM

SIGNATURE OF PHYSICIAN  
J. J. BROWN

SIGNATURE OF DECEASED  
JOHN J. BROWN

SIGNATURE OF WITNESSES  
J. J. BROWN

SIGNATURE OF DECEASED  
JOHN J. BROWN

SIGNATURE OF WITNESSES  
J. J. BROWN

SIGNATURE OF DECEASED  
JOHN J. BROWN

SIGNATURE OF WITNESSES  
J. J. BROWN

SIGNATURE OF DECEASED  
JOHN J. BROWN

SIGNATURE OF WITNESSES  
J. J. BROWN

SIGNATURE OF DECEASED  
JOHN J. BROWN

SIGNATURE OF WITNESSES  
J. J. BROWN

SIGNATURE OF DECEASED  
JOHN J. BROWN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be stated clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-240

50 2868

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2868

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Katherine

2. DATE OF DEATH

3/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3020 Kentucky Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3020 Kentucky Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. Md

26-03

D. STREET ADDRESS (If rural, give location)

3020 Kentucky Ave.

Length of stay in Baltimore

About 59 yrs.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Apr 1 1873

9. AGE (In years last birthday)

76

10. Under 1 Year

11

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House WORK

10B. KIND OF BUSINESS OR INDUSTRY

Housew. BRK-HOME

13. FATHER'S NAME

Unknown

11. BIRTHPLACE (State or foreign country)

Bohemia

12. CITIZEN OF WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Anthony W. Kasei

ADDRESS

3020 Kentucky Ave.

18. 442X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A)

Cerebral Hemorrhage (apoplexy)

DUE TO

Hypertensive Cardio Vascular Renal Disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 day

2

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 23, 1950, to March 23, 1950, that I last saw the deceased alive on March 23, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Pokorny

23B. ADDRESS

2200 E Madison St

23C. DATE SIGNED

3/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-28-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, Md

25. FUNERAL DIRECTOR

Frank Grocholson

ADDRESS

MAR 27 1950

131a



13-14-15

16-17-18

19-20-21

22-23-24

25-26-27

28-29-30

31-32-33

34-35-36

37-38-39

40-41-42

43-44-45



PLEASE WRITE PLAINLY, WITH INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-55  
134127

50 2869

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2869

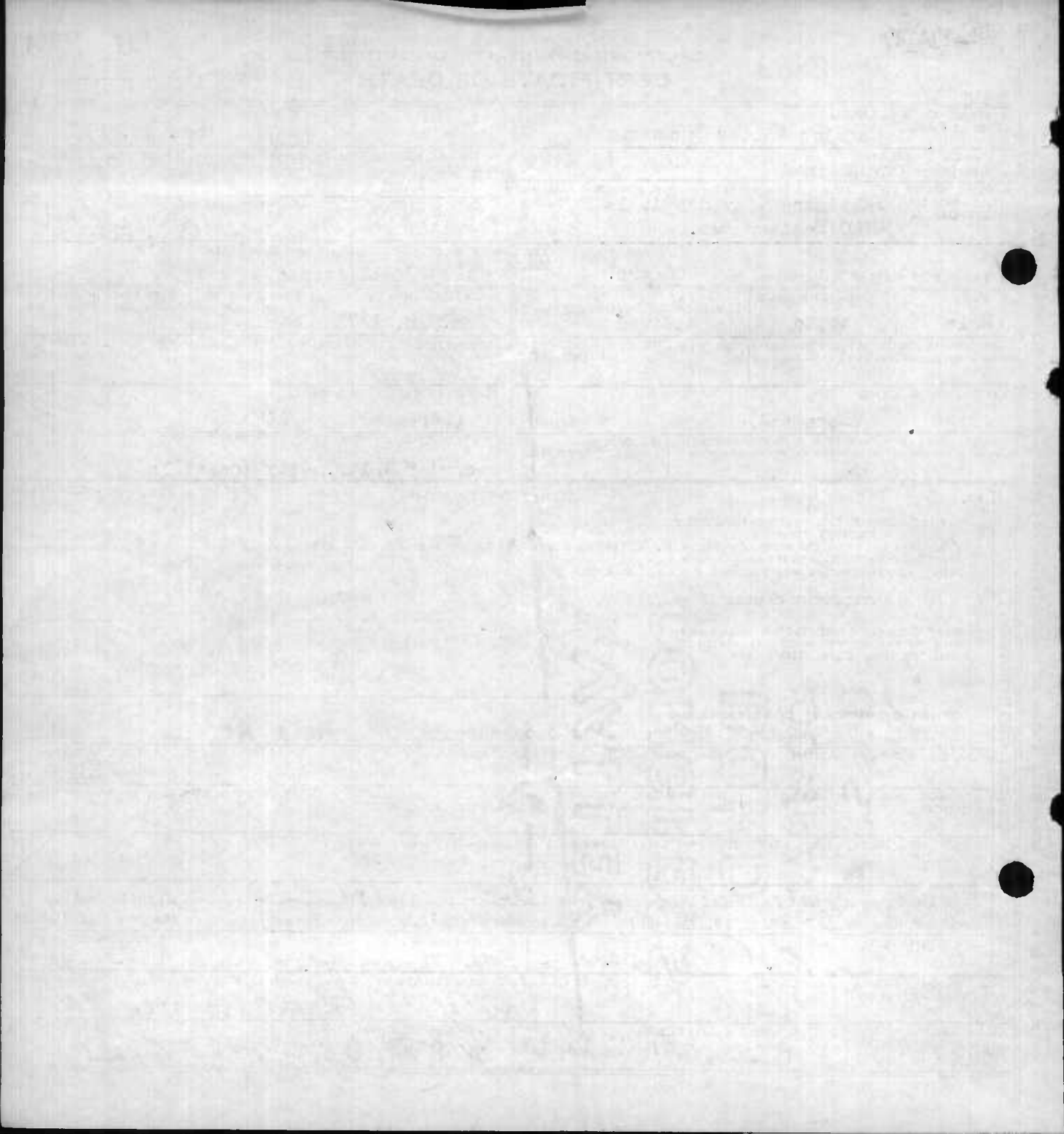
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Walter Ryckman			2. DATE OF DEATH Mar. 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-04A		
E. Length of stay in Baltimore 60 yrs.			D. STREET ADDRESS (If rural, give location) 1823 Odell Avenue		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 26, 1872	9. AGE (In years last birthday) 78	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME (Deceased)			14. MOTHER'S MAIDEN NAME (Deceased) ✓		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records* Balto. City Hospitals		

MEDICAL CERTIFICATION	18. 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple myeloma DUE TO	INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia DUE TO	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-10-1949 to 3-26-1950 that I last saw the deceased alive on 3-26-1950 and that death occurred at 3:15 P. M., from the causes and on the date stated above.					
23A. SIGNATURE J. H. Williams, M.D.		23B. ADDRESS 4940 Eastern Ave.		23C. DATE SIGNED 3-26-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 3/30/50		24C. NAME OF CEMETERY OR CREMATORY Glen Haven	
24D. LOCATION (City, town, or county) (State) Glen Burnie MD		24E. NAME OF FUNERAL DIRECTOR J. H. Williams		24F. ADDRESS 1217 St Paul St	
DATE RECEIVED BY LOCAL REGISTRAR MAR 28 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR'S ADDRESS	







21  
50 2870BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2870  
Registered No.

1. DATE OF DEATH 3/27/50	
2. NAME OF DECEASED (Type or Print) William F Fitzpatrick	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hosp.	
C. LENGTH OF STAY IN BALTIMORE Life	
D. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto.	
C. CITY OR TOWN Balto.	
D. STREET ADDRESS (If rural, give location) 1537 Argonne Drive	
E. AGE (In years last birthday) 47	
F. DATE OF BIRTH Aug 1, 1902	
G. SEX M	
H. COLOR OR RACE W	
I. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	
J. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
K. KIND OF BUSINESS OR INDUSTRY B & O R. R.	
L. FATHER'S NAME Frank Fitzpatrick	
M. MOTHER'S MAIDEN NAME Elizabeth Bush	
N. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	
O. SOCIAL SECURITY NO.	
P. INFORMANT Self	
Q. ADDRESS As Above	
R. CAUSE OF DEATH Bronchial Pneumonia, bilateral, with overwhelming toxemia.	
S. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO	
T. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	
U. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
V. DATE OF OPERATION 3/27	
W. MAJOR FINDINGS OF OPERATION	
X. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Y. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
Z. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
AA. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
AB. TIME (Month) (Day) (Year) (Hour) OF INJURY	
AC. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
AD. HOW DID INJURY OCCUR?	
AE. I hereby certify that I attended the deceased from 3/18, 1950, to 3/27, 1950, that I last saw the deceased alive on 3/27, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.	
AF. SIGNATURE Thomas W. May	
AG. ADDRESS 2800 York St. Balto. Md.	
AH. DATE SIGNED 3/29/50	
AI. BURIAL, CREMATION, REMOVAL (Specify) Burial	
AJ. DATE 3/29/50	
AK. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
AL. LOCATION (City, town, or county) (State) Balto. Md.	
AM. DATE RECEIVED BY LOCAL REGISTRAR MAR 28 1950	
AN. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
AO. FUNERAL DIRECTOR Wm. Cook Inc. 1217 St. Paul St	
AP. ADDRESS	



3/15/20

William E. Miller

Attorney

at

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

100 N. 4th St.

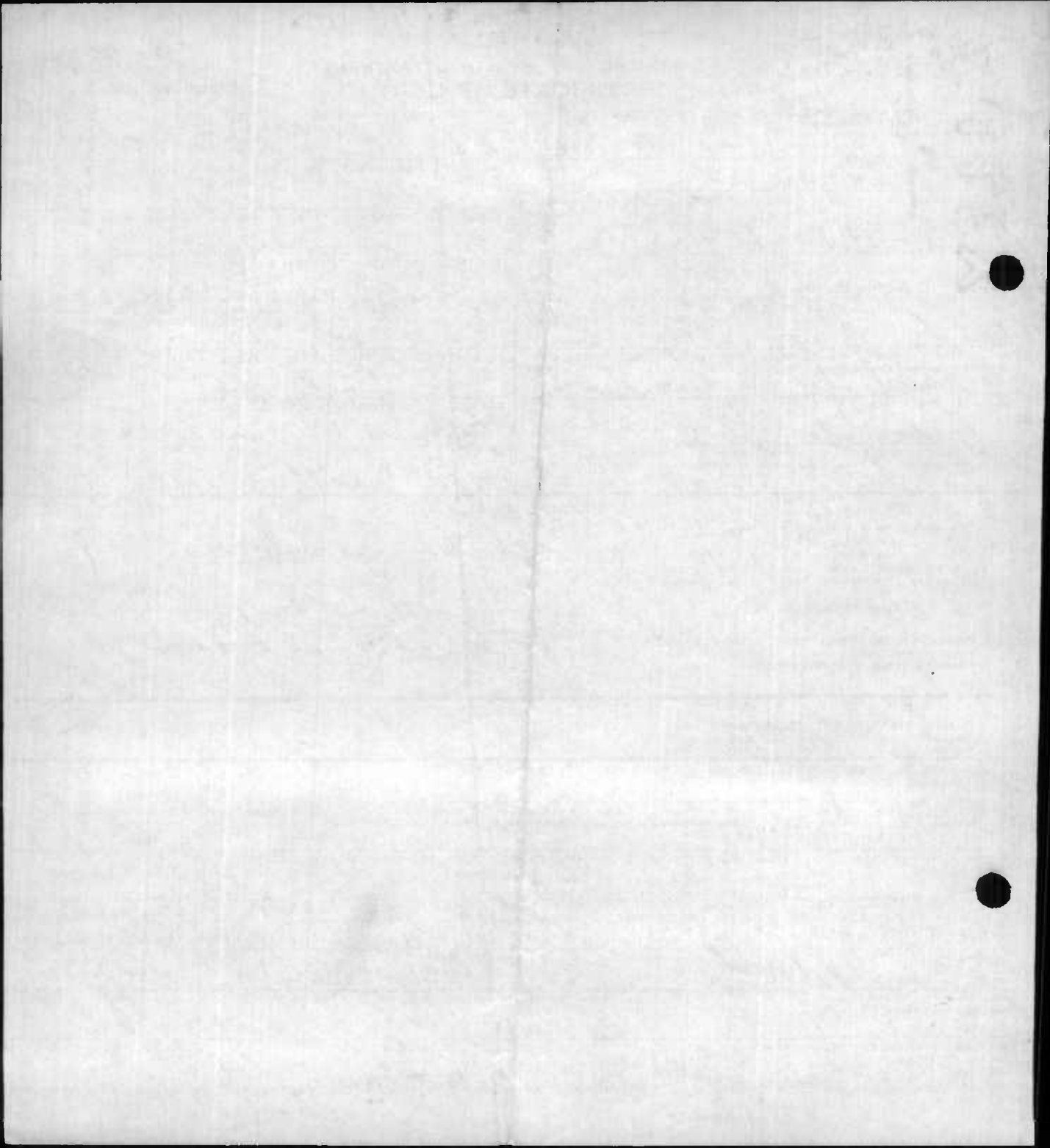
100 N. 4th St.



<div style="font-size: 2em; font-weight: bold; margin: 0;">-143</div> <div style="font-size: 1.5em; font-weight: bold; margin: 0;">50 2871</div>		<div style="font-size: 1.5em; font-weight: bold; margin: 0;">SEBALD</div> <div style="font-size: 1.5em; font-weight: bold; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em; font-weight: bold; margin: 0;">CERTIFICATE OF DEATH</div>		<div style="font-size: 1.5em; font-weight: bold; margin: 0;">50 2871</div> <div style="font-size: 1.2em; font-weight: bold; margin: 0;">Registered No.</div>	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
Dena M. SeBald			3/26/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION S.O.A. - St. Josephs Hospital			A. STATE Md		
			B. COUNTY		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Balto 9-09			1532 Aisquith St.		
Length of stay in Baltimore			Yrs. Mos. Days		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Year Months: Days
Female	White	Married	Oct 26-1887	62	11. Under 24 Hours Hours: Min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Balto. Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frederick Daub			Anna M. O'Connell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Peter F. SeBald 1532 Aisquith St	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) Coronary Thrombosis DUE TO (B) Atherosclerotic Cardiovascular Disease DUE TO (C)		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 10, 1949, to Mar 26, 1950, that I last saw the deceased alive on Mar 20, 1950, and that death occurred at 9:30 A.M., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Samuel Wolfe		1331 Skutumpah		3-27-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3/29/50		Holy Redeemer	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR ADDRESS			
Balto. Md.		1217 St. Paul St.			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
MAR 28 1950		Huntington Williams, Jr.		1217 St. Paul St.	
VS 150					

131a







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Francis D. Howard*

2. DATE  
OF  
DEATH

*March 26/1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

*md*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*00 4120 Marx Ave*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto 27-01*

D. STREET ADDRESS (If rural, give location)

*4120 Marx Ave*

Length of stay in Baltimore

5. SEX

*male*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*4/13/1865*

9. AGE (In years last birthday)

*84*

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired Chief Clerk*

10B. KIND OF BUSINESS OR

*Pa. R. R. Dept*

11. BIRTHPLACE (State or foreign country)

*md*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*J. E. A. T. Howard*

14. MOTHER'S MAIDEN NAME

*Catherine C. Wheeler*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

*no*

16. SOCIAL SECURITY NO.

*717-07-7490*

17. INFORMANT

ADDRESS

*B. J. Howard 1303 N. Kenwood Ave*

18. *443 X*

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Pulmonary Edema*

*2 days*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Cardio-Vascular Hypertensive Disease*

*3 years*

(C) *Arteriosclerosis*

*3 years*

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *January*, 19*48* to *March 26*, 19*50* that I last saw the deceased alive on *March 26*, 19*50*, and that death occurred *8:00 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Michael J. Dausch*

23B. ADDRESS

*4636 Belair Road*

23C. DATE SIGNED

*3/26/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*March 28 1950*

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*2000 1217 St Paul*



CERTIFICATE OF DEATH

STATE OF NEW YORK

Blank form with horizontal lines for text entry.



50 2873

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2873

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Herman Cousler

2. DATE  
OF  
DEATH

3-25-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Baltimore City Hospital

4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

1 Baltimore MD. 2644

D. STREET ADDRESS (If rural, give location)

31 S. Kresson ST.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Jan. 19 1878

9. AGE (in years  
last birthday)

72 Yrs.

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

BALTO. CITY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Cousler

14. MOTHER'S MAIDEN NAME

Johanna Schutzenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. 470.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchopneumonia Myocardial infarction

DUE TO Arteriosclerotic coronary artery disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Pulmonary Edema

DUE TO Arteriosclerotic Heart Disease

(over)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 7-28-, 1941, to 3-25-, 1950, that I last saw the  
deceased alive on 3-25-, 1950 and that death occurred at 11 15 PM from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B.C.H. 4940

Eastern Ave.

3-27-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

VS 150

98898

94a



See Document File 50-2873 for corrective authority

1 2/4/50

ES



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Eda White*

2. DATE  
OF  
DEATH

*3-24-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

*Provident Hosp.*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore City 16-01*

D. STREET ADDRESS (If rural, give location)

*821 N Carey St*

Length of stay in Baltimore \_\_\_\_\_

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Flurence Powell 821 N Carey St*

18. *260 X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Hypoglycemic shock*

*16 hrs.*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Diabetes mellitus, uncontrolled*

*5 mos.*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Essential Hypertension*

*4 mos.*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2-7-50*, 19\_\_, to *3-24-50*, 19\_\_, that I last saw the deceased alive on *1-24*, 19\_\_, and that death occurred at *3:23* p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

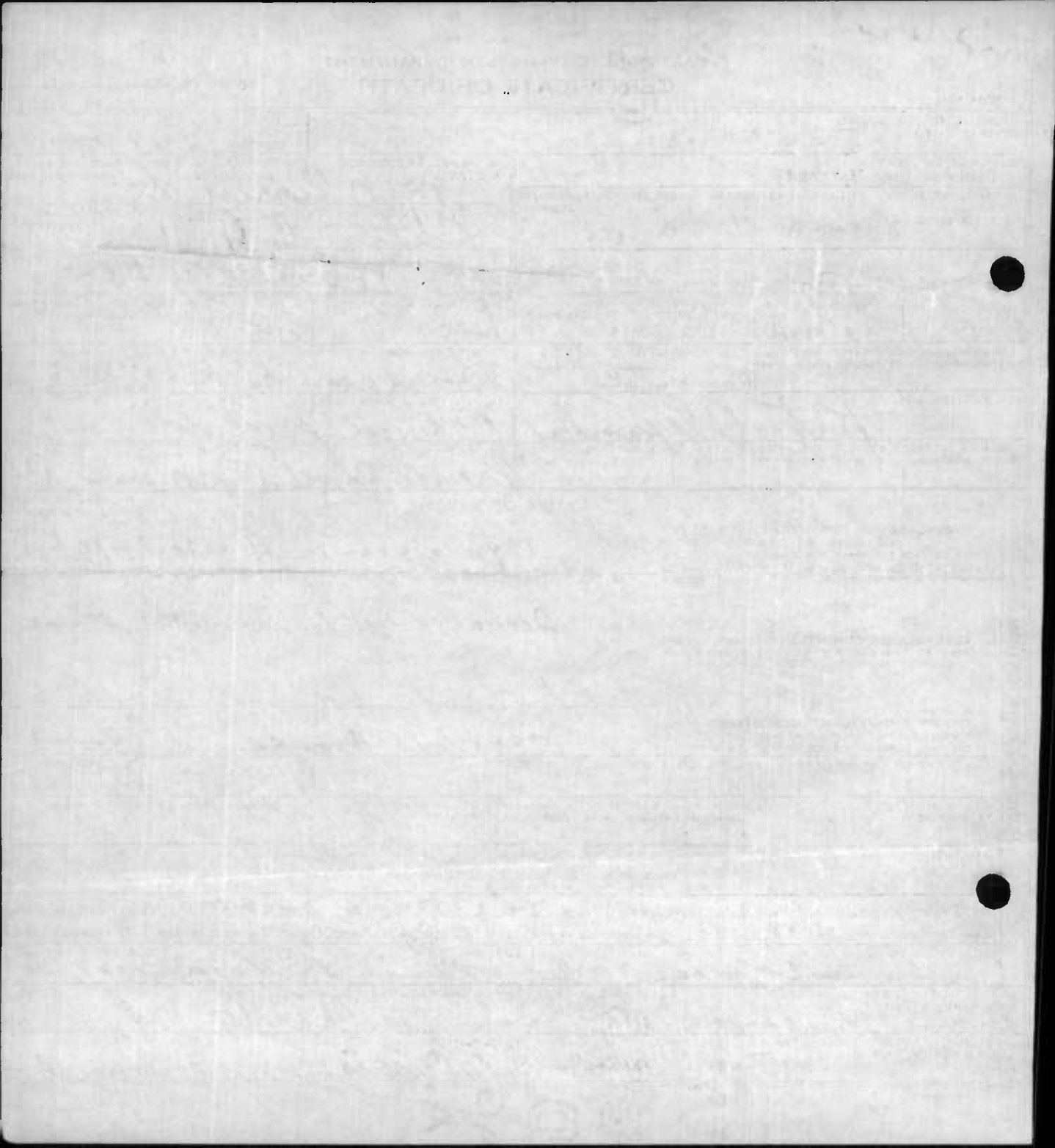
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2875  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*William Joseph Hood*

2. DATE  
OF  
DEATH

*MARCH 24  
1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*104 S. Gilmore ST*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *MARY LAND* B. COUNTY *CITY*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*BALTIMORE 19-04*

D. STREET ADDRESS (If rural, give location)

*104 S. Gilmore ST*

Length of stay in Baltimore

*65*

5. SEX

*MALE*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*WIDOWED*

8. DATE OF BIRTH

*December 11  
1873*

9. AGE (In years last birthday)

*76*

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*PAINTER*

10B. KIND OF BUSINESS OR INDUSTRY

*SELF EMPLOYED*

11. BIRTHPLACE (State or foreign country)

*TENNESSEE*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Milton Hood*

14. MOTHER'S MAIDEN NAME

*MONA LOVE*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*NO*

16. SOCIAL SECURITY NO.

*NONE*

17. INFORMANT

ADDRESS

*MRS KATHARINE WALSH 104 S Gilmore*

18. *163X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cancer of the left lung*  
DUE TO *Site + type unknown*

*2 YRS*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Chronic myocardial degeneration*  
*Malnutrition (arteriosclerosis)*

*years*

*3 months*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 29, 1944*, to *MARCH 24, 1950*, that I last saw the deceased alive on *MARCH 22, 1950*, and that death occurred at *7:30 P* m., from the causes and on the date stated above.

23A. SIGNATURE

*Melvin N. Burden*

23B. ADDRESS

*2030 W Fayette ST*

23C. DATE SIGNED

*3/24/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 28/50*

24C. NAME OF CEMETERY OR CREMATORY

*Londond Park*

24D. LOCATION (City, town, or county)

*Bald. Md*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 28 1950*

REGISTRAR'S SIGNATURE

*Thurston Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*Geo. H. Beyer Jr 1512 Hollins St*







250  
50 2876RICHWEIN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2876  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lena Richwein

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONLillian A. Richwein, Jr.  
Home Va. Rd. Paged  
1200 Valley St.

Length of stay in Baltimore

91 yrs. 4 mos. 4 days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6 - N. E. St. Louis St.

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 24, 1858

9. AGE (in years last birthday)

91

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Church Rectory

13. FATHER'S NAME

Henry Richwein

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Christine Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT (Name and address)

Lillian A. Richwein, Jr.  
1200 Valley St.

18. 442 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cardio Vascular-Renal Disease

3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arterio Sclerosis

10 yrs

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1950, to March 26, 1950, that I last saw the deceased alive on March 25, 1950, and that death occurred at 3 A.M., from the causes and on the date stated above.

23A. SIGNATURE

E. L. Hall M.D.

23B. ADDRESS

1631 E. North Ave

23C. DATE SIGNED

March 26 - 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

March 29/50

Londond Park

Bald. Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

Huntington Williams, M.D.

Geo L. Beyers Jr 1512 Hollins St



CERTIFICATE OF DEATH

Name of Deceased \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Date of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_



6231621

50 2877

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2877  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alice Virginia Carter

2. DATE  
OF  
DEATH

3-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1213 W. Lexington Street

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Feb. 28, 1887

9. AGE (In years  
last birthday)

63

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George Atkins

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Kidwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Ave.

18. 420.1 155X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Primary Carcinoma of Liver.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 3-21 1950 to 3-24 1950, that I last saw the  
deceased alive on 3-24 1950, and that death occurred at 2:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

4940 Eastern Avenue

3-25-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

Huntington Williams

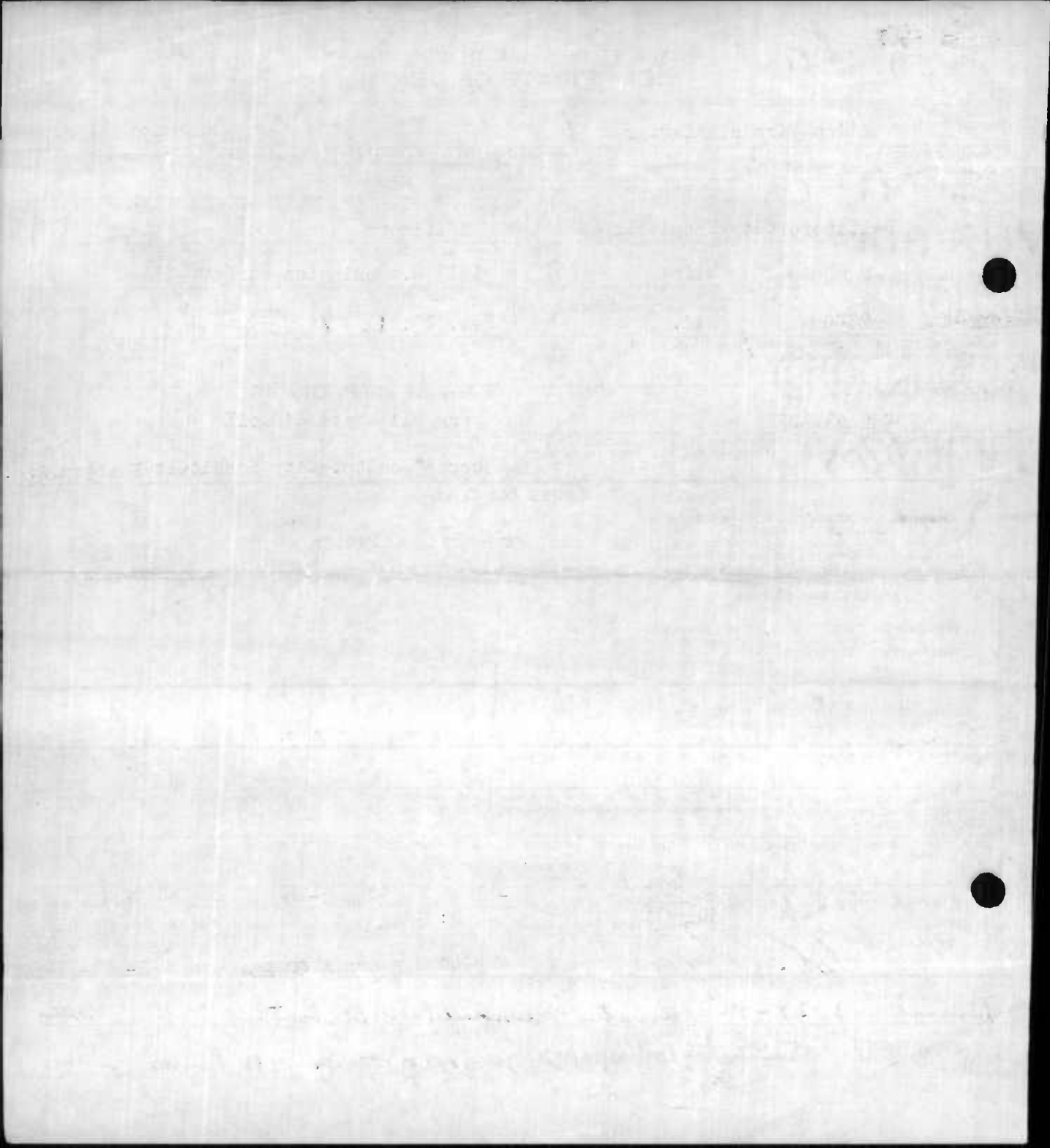
Wm. G. G. Jones 916 Penna ave

VS 150

46F

MEDICAL CERTIFICATION







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2878  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**JOSEPH G KATZ**

2. DATE  
OF  
DEATH

**3-27-50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

**3805 Belle Ave**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**3805 Belle Ave**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Widowed**

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

**Russian**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Aaron**

14. MOTHER'S MAIDEN NAME

**Esther**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Lymone Spector 3805 Belle Ave**

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

**ARTERIOSCLEROTIC Cardio-Vascular Disease**

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

**2 YRS.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

**CARCINOMA OF PROSTATE**

**6 YRS.**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

**Feb. 8, 1944**

19B. MAJOR FINDINGS OF OPERATION

**CARCINOMA OF PROSTATE**

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from **July 1, 1948** to **Mar 27, 1950** that I last saw the deceased alive on **3/25, 1950** and that death occurred at **7 p. m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Elmer J. Hume**

23B. ADDRESS

**1801 Eutaw Pl**

23C. DATE SIGNED

**3/28/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**3-28-50**

24C. NAME OF CEMETERY OR CREMATORY

**Hebrew Friendship**

24D. LOCATION (City, town, or county)

**Balto Md**

DATE RECEIVED BY LOCAL REGISTRAR

**MAR 28 1950**

REGISTRAR'S SIGNATURE

**Elmer J. Hume**

25. FUNERAL DIRECTOR

**Jack K. Kung**

ADDRESS

**2100 Eutaw Pl**



Amherst  
1801



50 2879

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2879  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John H. DUNGAN

2. DATE  
OF  
DEATH

3-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

726 E. Fort Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

24-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

726 E. Fort Ave.

Length of stay in Baltimore

50

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1-7-1874

9. AGE (In years  
last birthday)

76

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Butcher

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

LOTA BROOKS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

212-107778

17. INFORMANT

ADDRESS

MARGARET Schmincke 726 E. Fort Ave

18. 4221

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Jan. 1950

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) arterio-sclerotic  
disease of the heart

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from Jan. 1950 to Mar. 25, 1950, that I last saw the deceased alive on Mar. 24, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Sullivan

23B. ADDRESS

107 E. Waverly St

23C. DATE SIGNED

3/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

3-25-50

24C. NAME OF CEMETERY OR CREMATORY

CEDAR HILL

24D. LOCATION (City, town, or county)

A.A. Co.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Charles F. Hill

ADDRESS

1501 E. Fort Ave.

VS 150

931

MEDICAL CERTIFICATION



John H. Johnson

MD

222 E. 10th Ave

St. Louis, Mo

M. W. Johnson

1-2-1914

St. Louis, Mo

John H. Johnson

St. Louis, Mo

St. Louis, Mo

St. Louis, Mo

St. Louis, Mo

St. Louis, Mo

St. Louis, Mo

St. Louis, Mo

St. Louis, Mo











50 2881

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2881  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)P.  
Elmer Rader2. DATE  
OF  
DEATH

3/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

mercy Hospital

length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

# 14

D. STREET ADDRESS (If rural, give location)

2716 Linwood Ave.

8. DATE OF BIRTH

2/28/08

9. AGE (In years last birthday)

42

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

salesman

10B. KIND OF BUSINESS OR INDUSTRY

insurance

13. FATHER'S NAME

William Rader

14. MOTHER'S MAIDEN NAME

marie gohr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Dorothy Rader - 2716 Linwood

18. 550.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

cardiac failure

3 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

generalized peritonitis

9 day

(C)

ruptured appendix + cecum

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3/14/50 / 3/18/50

19B. MAJOR FINDINGS OF OPERATION

appendical abscess / ruptured cecum + ileum

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 3/23, 1950, to 3/27, 1950, that I last saw the deceased alive on 3/27, 1950, and that death occurred at 8 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Benton Lock MD

M. D.

23B. ADDRESS

mercy Hosp.

23C. DATE SIGNED

3/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/30/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Belle Mead

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 28 1950

REGISTRAR'S SIGNATURE

Huntington Hill

25. FUNERAL DIRECTOR

ADDRESS

S. J. Luck - 5305 Harford Rd.

VS 150

27480 882

121

MEDICAL CERTIFICATION



DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into a form with various fields and headings.]*



50 2882

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2882

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Joseph J. Velker

2. DATE  
OF  
DEATH

March 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2229 E. Federal St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

Length of stay in Baltimore

78

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan. 7, 1872

9. AGE (In years  
last birthday)

78

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Sheet Metal

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Hloysius Velker

14. MOTHER'S MAIDEN NAME

Gertrude Bergamin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

J. Zocinner Church Home &amp; Hospital

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Heart Failure - Constructive Pericarditis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Cerebral Hemorrhage

4 days

DUE TO

(C)

Hypertensive Heart Disease

4 years

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from Mar. 26, 1950, to Mar. 27, 1950, that I last saw the  
deceased alive on Mar. 27, 1950, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

22A. SIGNATURE

James J. Means

M. D.

22B. ADDRESS

Church Home &amp; Hospital

22C. DATE SIGNED

3/27/50

23A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

23B. DATE

3/30/50

23C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

23D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 28 1950

REGISTRAR'S SIGNATURE

Wilmington, Delaware

24. FUNERAL DIRECTOR

L. J. Buck 5305 Harford Rd.

ADDRESS



1950

RECEIVED AT THE OFFICE OF THE

DEPARTMENT OF HEALTH

STATE OF NEW YORK

IN SENATE

January 10, 1950

REPORT OF THE

COMMISSIONER OF HEALTH

ON THE

STATE OF THE

HEALTH OF THE

STATE OF NEW YORK

FOR THE YEAR 1949

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

1950

PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK

ALBANY, NEW YORK



50-323  
50 2883

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2883

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Ellen Stockhill

2. DATE OF DEATH

3/25/50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Woodstock 6200

D. STREET ADDRESS (If rural, give location)

Offutt Road

Length of stay in Baltimore

1 Yrs. Mos. Days

SEX  
F

6. COLOR OR RACE  
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

12-8-1895

9. AGE (In years last birthday)

54

If Under 1 Year Months: Days

53

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter Burns

(decd)

14. MOTHER'S MAIDEN NAME

Johanna W. Ralen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Henry Stockhill

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

approx 1 day

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 3/25, 1950, to 3/25, 1950, that I last saw the deceased alive on 3/25, 1950, and that death occurred at 7:34 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert J. Lurigan

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

3/25/50

24A. BURIAL, CREMATION, OR REMOVAL (Specify)

Burial Mar 29-50

24B. NAME OF CEMETERY OR CREMATORY

St. Peter Cemo.

24C. LOCATION (City, town, or county)

Baltimore St. Charles Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 28 1950

REGISTRAR'S SIGNATURE

Wm. H. Hollingsworth

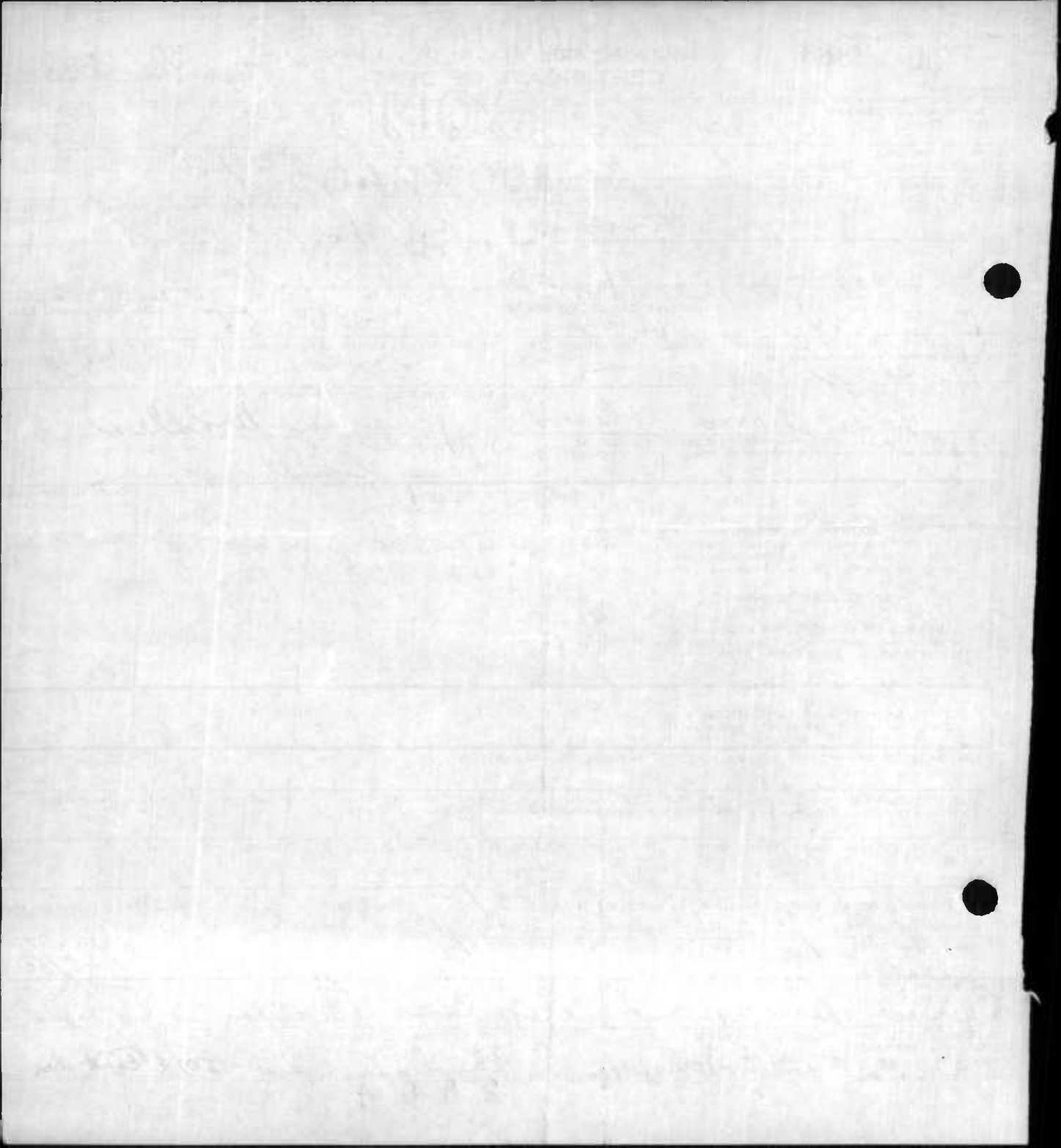
25. FUNERAL DIRECTOR

Charles F. Dill

ADDRESS

1501 E. Fort Ave







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2884  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick A Hall

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

423 S. Eaton Street

Length of stay in Baltimore

SEX  
M

6. COLOR OR RACE  
W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Feb 16 1921

9. AGE (in years  
last birthday)

29

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Construction Work

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryville Tenn

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sam J. Hall

14. MOTHER'S MAIDEN NAME

Mertel Simmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Obey Hall 423 S Eaton St.

18. E814.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Fractured skull

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Fractured mandible

(C) Subarachnoid hemorrhage

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

(railroad tracks)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

March 26, 1950 5:30 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Thrown from motorcycle ( rider )

I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.O. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

March 27, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

MARCH 29, 50

24C. NAME OF CEMETERY OR CREMATORY

NELSON CEMETERY

24D. LOCATION (City, town, or county)

WELLSVILLE TENN.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston H. Williams

25. FUNERAL DIRECTOR

ADDRESS

1800 E LOMBARD ST



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	



50 2885

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2885  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPHINE C VILLA

2. DATE  
OF  
DEATH

MARCH 26 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

711 N. PATTERSON PARK AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 7-03

D. STREET ADDRESS (If rural, give location)

711 N PATTERSON PARK AVE

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED.

8. DATE OF BIRTH

JULY 4 1867

9. AGE (In years  
last birthday)

82

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSE WORK

10B. KIND OF BUSINESS OR  
INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NICHOLAS PORCELLA.

14. MOTHER'S MAIDEN NAME

CATHERINE PORCELLA.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE.

17. INFORMANT

ADDRESS

STELLA KLANK 711 N PATTERSON PARK AVE

18. 4200

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Acute Cardiac Failure

DUE TO

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

5 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized Atherosclerosis

5 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from March 1, 1944 to March 26, 1950, that I last saw the  
deceased alive on March 25, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Isaac Roen

23B. ADDRESS

2413E Monument St

23C. DATE SIGNED

3/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

MARCH 29 1950

24C. NAME OF CEMETERY OR CREMATORY

ST VINCENT CEMETERY

24D. LOCATION (City, town, or county)

BELAIR RD &amp; SINCLAIR LANE MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Halliwell

25. FUNERAL DIRECTOR

ADDRESS

1800 E LOMBARD ST



1917

1917

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1917



## MEDICAL EXAMINER'S RELEASE

50 2886

BALTIMORE CITY HEALTH DEPARTMENT

50 2886

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sarah Theresa Dietrich

2. DATE  
OF  
DEATH

March 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

Essex

5300

D. STREET ADDRESS (If rural, give location)

14 Helena Avenue

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

41 St. Joseph's Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

Fe.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

P

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs M. Zimmerman

18. E903.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY

H. J. McCafferty, M.D.  
for C. J. Lubinski, M.D.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

March 9, 1950

19B. MAJOR FINDINGS OF OPERATION

Open Reduction and Insertion of Smith-Petersen Nail

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

At Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

14 Helena Avenue

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

February 28, 1950

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped and fell at home  
Patient fell down at homeI hereby certify that I attended the deceased from 3/2/1950, to 3/27/1950 that I last saw the  
deceased alive on 3/27/1950, and that death occurred at 6:10 A.M. from the causes and on the date stated above.

23A. SIGNATURE

J. A. Redger

23B. ADDRESS

M. D.

1100 N. Caroline Street

23C. DATE SIGNED

3/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

St Paul Cemetery

24D. LOCATION (City, town, or county)

Balto City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

J. J. Boydinski 1417 Eastern Ave  
Essex

VS 150

N-820.1

186a



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Signature of physician		8. Signature of registrar	
9. Name of informant		10. Relationship to deceased		11. Signature of informant		12. Signature of registrar	
13. Name of informant		14. Relationship to deceased		15. Signature of informant		16. Signature of registrar	
17. Name of informant		18. Relationship to deceased		19. Signature of informant		20. Signature of registrar	
21. Name of informant		22. Relationship to deceased		23. Signature of informant		24. Signature of registrar	
25. Name of informant		26. Relationship to deceased		27. Signature of informant		28. Signature of registrar	
29. Name of informant		30. Relationship to deceased		31. Signature of informant		32. Signature of registrar	
33. Name of informant		34. Relationship to deceased		35. Signature of informant		36. Signature of registrar	
37. Name of informant		38. Relationship to deceased		39. Signature of informant		40. Signature of registrar	
41. Name of informant		42. Relationship to deceased		43. Signature of informant		44. Signature of registrar	
45. Name of informant		46. Relationship to deceased		47. Signature of informant		48. Signature of registrar	
49. Name of informant		50. Relationship to deceased		51. Signature of informant		52. Signature of registrar	
53. Name of informant		54. Relationship to deceased		55. Signature of informant		56. Signature of registrar	
57. Name of informant		58. Relationship to deceased		59. Signature of informant		60. Signature of registrar	
61. Name of informant		62. Relationship to deceased		63. Signature of informant		64. Signature of registrar	
65. Name of informant		66. Relationship to deceased		67. Signature of informant		68. Signature of registrar	
69. Name of informant		70. Relationship to deceased		71. Signature of informant		72. Signature of registrar	
73. Name of informant		74. Relationship to deceased		75. Signature of informant		76. Signature of registrar	
77. Name of informant		78. Relationship to deceased		79. Signature of informant		80. Signature of registrar	
81. Name of informant		82. Relationship to deceased		83. Signature of informant		84. Signature of registrar	
85. Name of informant		86. Relationship to deceased		87. Signature of informant		88. Signature of registrar	
89. Name of informant		90. Relationship to deceased		91. Signature of informant		92. Signature of registrar	
93. Name of informant		94. Relationship to deceased		95. Signature of informant		96. Signature of registrar	
97. Name of informant		98. Relationship to deceased		99. Signature of informant		100. Signature of registrar	



-561

50 2887  
49-18645

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2887  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Phyllis Summerville</i>		2. DATE OF DEATH <i>March 25, 1950</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Anne Arundel</i>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Seneca Park 5000</i>	
Length of stay in Baltimore SEX <i>Female</i> 6. COLOR OR RACE <i>Colored</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Child</i>		8. DATE OF BIRTH <i>Sept 3 1945</i> 9. AGE (In years last birthday) <i>6</i> 11 Under 1 Year Months: Days <i>6 22</i> 11 Under 24 Hours Hours: Min. <i>22</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Johns Hopkins</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert Summerville</i>		14. MOTHER'S MAIDEN NAME <i>June Ida Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>JOHNS HOPKINS HOSPITAL</i>	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

CAUSE OF DEATH

18. <i>340.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>pneumococcal meningitis</i> 1 week	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C)	

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from *3-25* 1950, to *3-25* 1950, that I last saw the deceased alive on *3-25* 1950, and that death occurred at *855 P.* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Jenard Z. Rosenzweig</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>27 Mar '50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Mar. 29/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Wayman-Goodhope</i>
24D. LOCATION (City, town, or county) (State) <i>Jones station Ind</i>	25. FUNERAL DIRECTOR <i>28-83 Johnson</i>	ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 28 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington, Delaware</i>	

*Annapolis 81a*



REGISTRATION OF DEATH  
CERTIFICATE OF DEATH

1. Name of deceased person (Full name)

2. Date of birth

3. Date of death

4. Place of death



50 2888

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2888

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JEMEINA YOUNGER

2. DATE  
OF  
DEATH 3/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 127 E. Randall St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE Md. B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 24-04D. STREET ADDRESS (If rural, give location)  
127 E. Randall St.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

13. FATHER'S NAME

William Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

12/4/1864

9. AGE (In years;  
last birthday)

85

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.

14. MOTHER'S MAIDEN NAME

Rachael Hobbs

17. INFORMANT

Family - Same

ADDRESS

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio sclerotic heart  
disease.May 24th,  
1944.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) General arterio sclerosis;  
chronic aortic regurgitation  
of heart.

?

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 24, 1944 to Mar. 26, 1950 that I last saw the deceased alive on 3/26/50 and that death occurred at P. m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Heibel

23B. ADDRESS

M. D. 1226 Hanover St. 88

23C. DATE SIGNED

3/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/29/50

24C. NAME OF CEMETERY OR CREMATORY

Mount Olivet

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

James L. L. L.

ADDRESS

\* 130 E. Port Ave.



CERTIFICATE OF DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

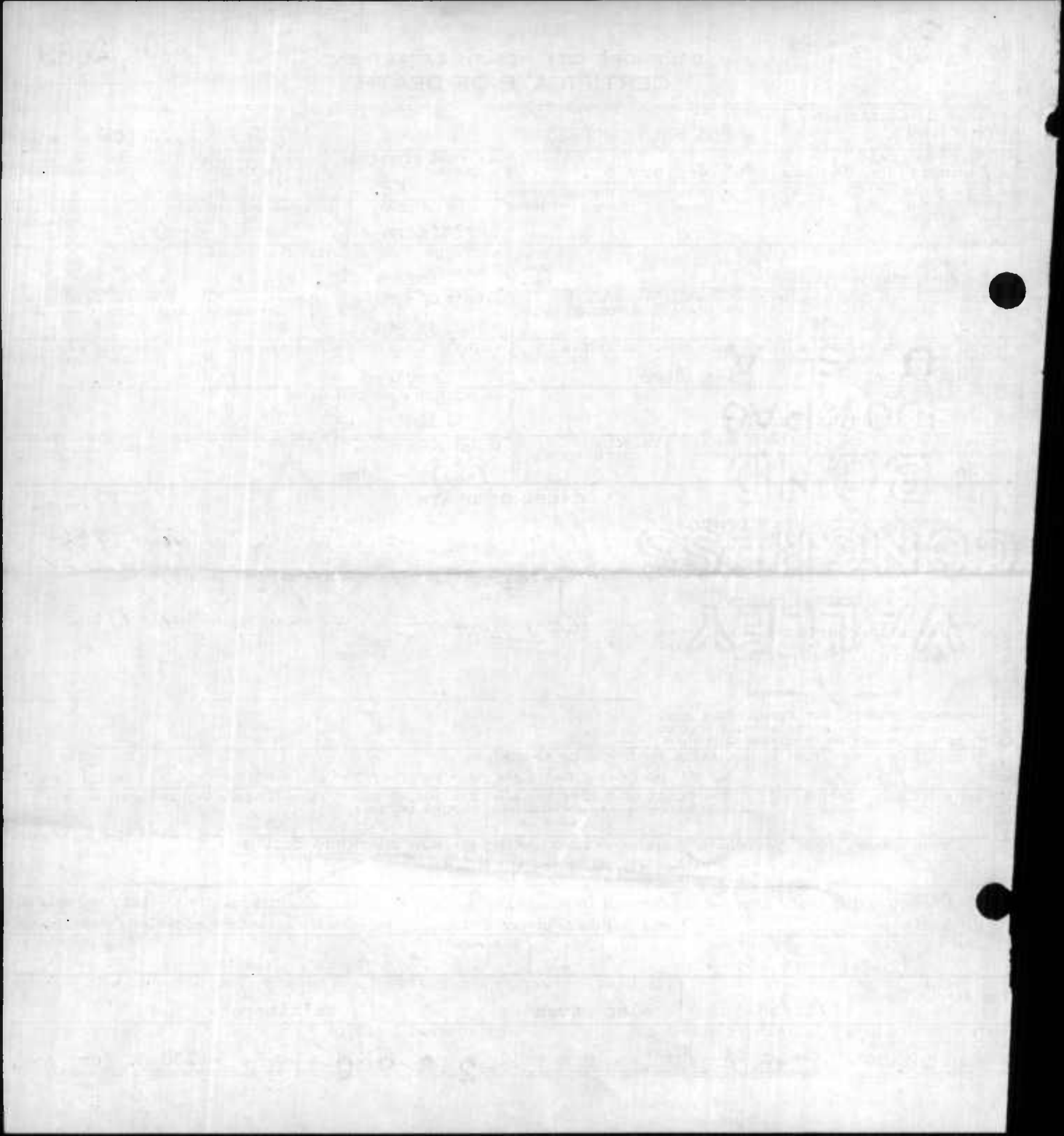
DATE OF CREMATION

DATE OF INTERMENT











**CERTIFICATE CORRECTED** 3/30/50

**50 2890**

**BALTIMORE CITY HEALTH DEPARTMENT**

**CERTIFICATE OF DEATH**

**50 2890**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) CHARLES STELLMACHER

2. DATE OF DEATH 3/25/50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
Wayland General

Length of stay in Baltimore \_\_\_\_\_  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ Days \_\_\_\_\_

SEX M 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) \_\_\_\_\_

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Dry Dock Operator

10B. KIND OF BUSINESS OR INDUSTRY Md.

13. FATHER'S NAME \_\_\_\_\_

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, war unknown) No. (If yes, give war or dates of service) \_\_\_\_\_

16. SOCIAL SECURITY NO. \_\_\_\_\_

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Md. B. COUNTY Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 5200

D. STREET ADDRESS (If rural, give location)  
3. W. Ninth Ave Brooklyn

8. DATE OF BIRTH April 13 1890 9. AGE (In years last birthday) 60 11 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.

11. BIRTH PLACE (State or foreign country)  
Germany

12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

14. MOTHER'S MAIDEN NAME \_\_\_\_\_

17. INFORMANT Family - Same ADDRESS \_\_\_\_\_

18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH  
(A) Cerebrovascular accident  
DUE TO

ANTECEDENT CAUSES  
(B) Hypertension  
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
(C) \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH  
6 days

19A. DATE OF OPERATION \_\_\_\_\_

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_

19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20. AUTOPSY? YES ☐ NO ☐

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 3/20, 1950, 3/25, 1950, that I last saw the deceased alive on 3/23, 1950, and that death occurred at 7 P.m., from the causes and on the date stated above.

23A. SIGNATURE Charles D. Black M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify) B.

DATE RECEIVED BY LOCAL REGISTRAR MAR 28 1950

23B. ADDRESS Wayland General

24B. DATE 3-29-50

REGISTRAR'S SIGNATURE Christington Hillman

23C. DATE SIGNED 3/25/50

24C. NAME OF CEMETERY OR CREMATORY Cedar Hill

24D. LOCATION (City, town, or county) (State) Baltimore

25. FUNERAL DIRECTOR James H. Cuddy ADDRESS 130 E. Font Ave.

VS 150

4964V

83a

MEDICAL CERTIFICATION



STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
COLUMBUS, OHIO

DATE

TIME

PLACE

CAUSE

MANNER

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

INDUSTRY

TRADE

PROFESSION

ART

SCIENCE

LITERATURE

COMMERCE

MANUFACTURES

TRANSPORTATION

COMMUNICATIONS

MINING

AGRICULTURE

FISHERY

FORESTRY

INDUSTRIES

TRADES

PROFESSIONS

ARTS

SCIENCES

LITERATURES

COMMERCE

MANUFACTURES

TRANSPORTATION

COMMUNICATIONS

MINING

AGRICULTURE

FISHERY

FORESTRY

INDUSTRIES

TRADES

PROFESSIONS

ARTS



SITSKORN

50 2891

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2891

NO. 50-03314

NAME OF DECEASED  
(Type or Print)

Arthur Sitskorn

2. DATE  
OF  
DEATH

3/26/50

## 5. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Arthur W. Sitskorn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1448 Andre Street

8. DATE OF BIRTH

7-6-1950

9. AGE (In years last birthday)

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Evelyn Whitehurst

17. INFORMANT

ADDRESS

18. 7620

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/26/50, 19, to 3/26/50, 19, that I last saw the deceased alive on 3/26/50, 19, and that death occurred at 8:40 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

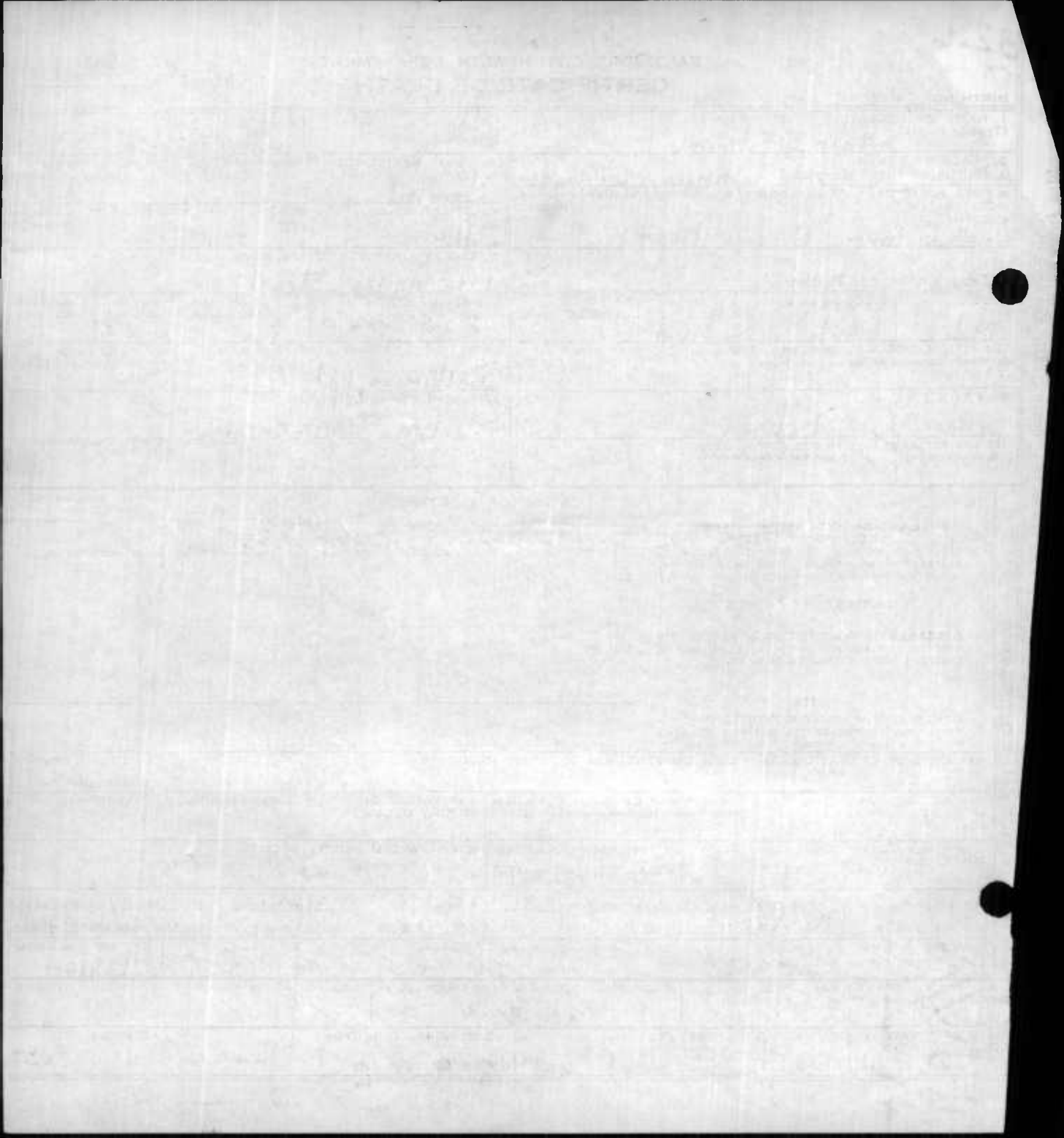
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS







146

IOANNA J. PAVLEROS

50 2892

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2892  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Joanna J Pavleros</i>		2. DATE OF DEATH <i>3-25-50.</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2402 Lafayette Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <i>MD</i> COUNTY <i>W</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>16-05</i>	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	

6. SEX <i>f.</i>	6. COLOR OR RACE <i>M</i>	7. SINGLE (MARRIED) WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>?</i>	9. AGE (In years last birthday) <i>66-</i>	If Under 1 Year Months Days	If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>unk.</i>		14. MOTHER'S MAIDEN NAME <i>unk.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Pavleros</i>		ADDRESS <i>2402 Lafayette Ave</i>		

18. <i>4/20.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO <i>Degeneration of the Myocard</i> (B) <i>Hypertension</i> <i>Cardiac failure.</i> DUE TO <i>Obesity</i> (C)	INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb. 2, 1950* to *3/26/50* that I last saw the deceased alive on *3/26*, 19*50*, and that death occurred at *4:30* m., from the cause and on the date stated above.

23A. SIGNATURE <i>J. Murphy</i>	23B. ADDRESS <i>5103 N. Charles St. Baltimore 18, Md.</i>	23C. DATE SIGNED <i>APR 15 1950</i>
---------------------------------	---	-------------------------------------

24A. (BURIAL, CREMATION, REMOVAL) (Specify)	24B. DATE <i>3-28-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Greek Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Windsor Mill Rd. Baltimore 18, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Wilmington Williams, Md.</i>	25. FUNERAL DIRECTOR <i>Kampros Inc.</i>	ADDRESS <i>440 E. North</i>

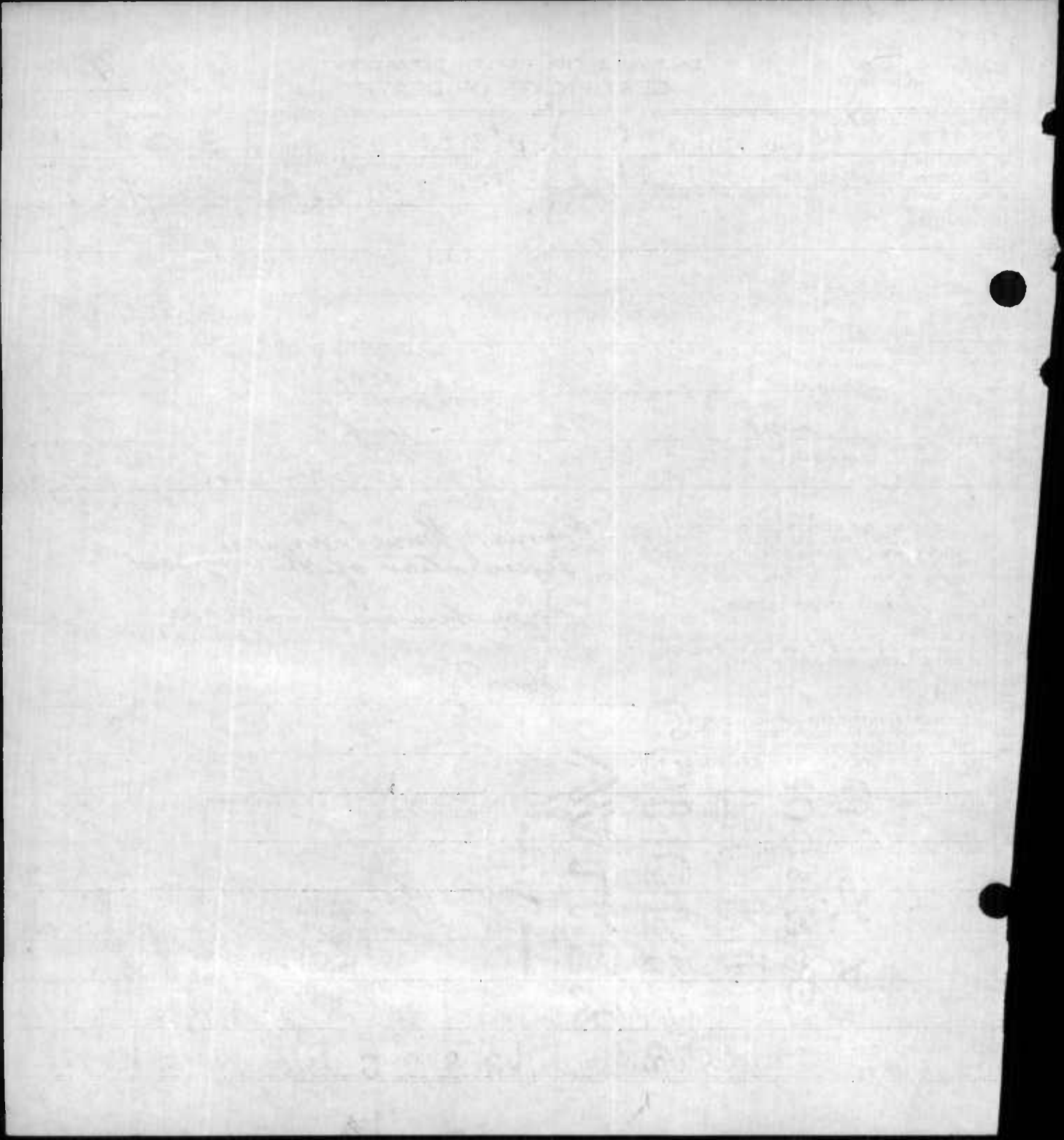
MAR 28 1950  
VS 150

93D *AW*

MEDICAL CERTIFICATION

causes of death clearly and legibly.







Causes of death clearly and legibly.

516

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2893

50 2893

Registered No.

1. NAME OF DECEASED  
(Type or Print)

FRED V. DUNBAR

2. DATE  
OF  
DEATH

Mar. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Edgewood Nursing Home

6000 Bellona Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

St. Mary's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ridge

6800

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Own Farm

13. FATHER'S NAME

Dunbar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

May 28, 1871

9. AGE (In years, last birthday)

78

11 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Katherine Jones

17. INFORMANT

ADDRESS

Mr. John G. Dunbar 7117 Oxford Rd.

18. 443x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral hemorrhage

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardio-Vascular disease

5 yrs

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945 to 26 Mar, 1950, that I last saw the deceased alive on 25 Mar, 1950, and that death occurred at 8:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

G. Allan Smith

23B. ADDRESS

1134 E. Belvidere Ave

23C. DATE SIGNED

28 Mar 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/29/50

24C. NAME OF CEMETERY OR CREMATORY

Trinity Cem. Yard

24D. LOCATION (City, town, or county) (State)

St. Mary's, City, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

MAR 28 1950

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS Balto., Md.

MEDICAL CERTIFICATION







7-624

50 2894

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2894

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Anna Sophia Zirckel</i>		2. DATE OF DEATH <i>27 March 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>231 Chancery Rd.</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Nov. 11, 1865</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>84</i>
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Lewis Lachenmayer</i>		14. MOTHER'S MAIDEN NAME <i>Pauline Koerner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. Gordon M. Holland</i>		ADDRESS <i>Catonsville 103 N. Rolling Rd</i>	

18. <i>330 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Subarachnoid Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Generalized arteriosclerosis</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Senility</i>		
19A. DATE OF OPERATION <i>None</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>None</i>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

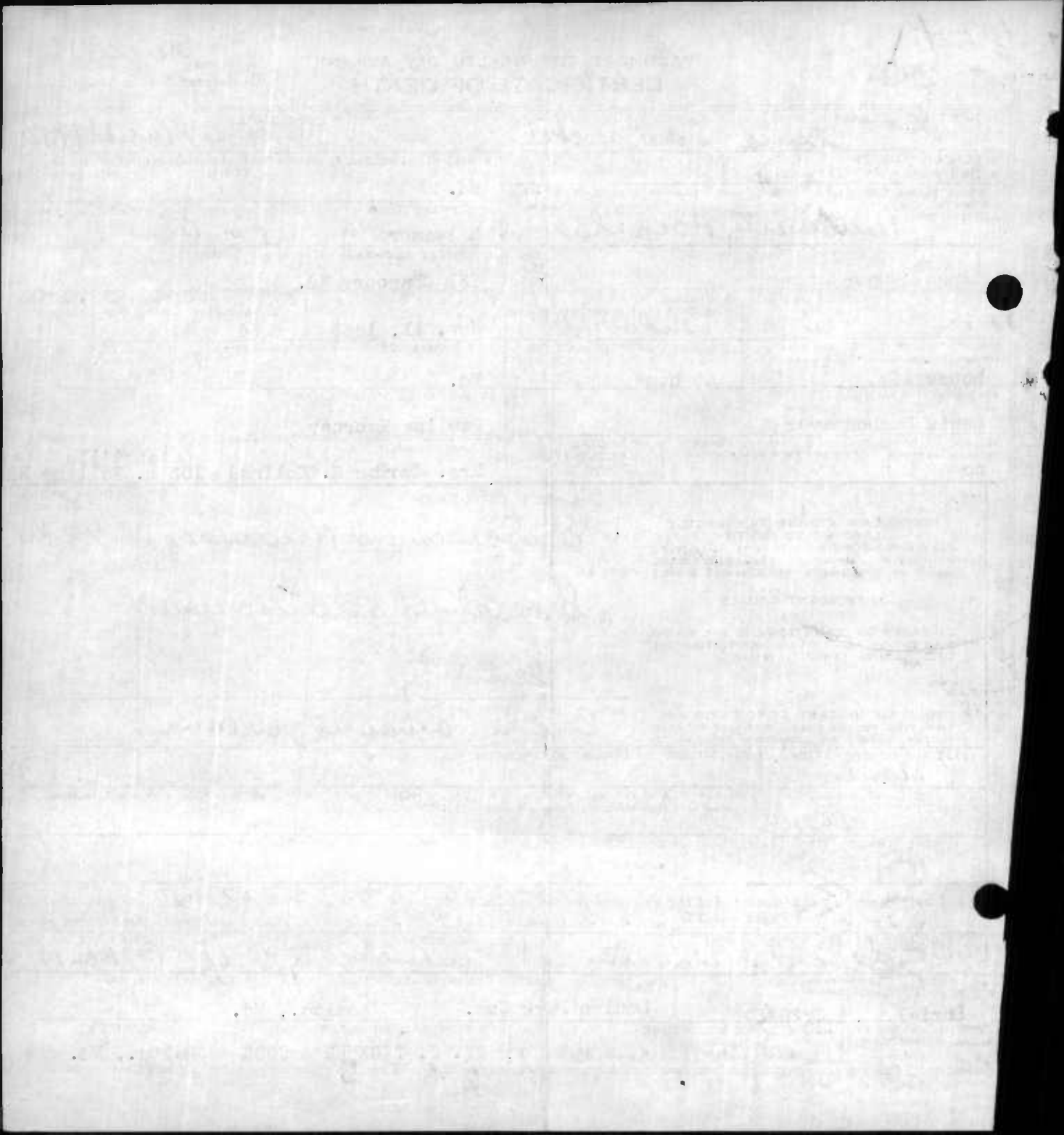
22. I hereby certify that I attended the deceased from *3-26, 1950* to *3-27, 1950*, that I last saw the deceased alive on *27 Mar, 1950*, and that death occurred at *4:40 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Harold A. Martin</i>	23B. ADDRESS <i>University Hosp</i>	23C. DATE SIGNED <i>27 Mar. 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/29/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	25. FUNERAL DIRECTOR <i>WM. J. TICKNER &amp; SONS</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 28 1950</i>		ADDRESS <i>Balto., Md.</i>

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500

50 2895

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2895

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Eva Cook Bowen

2. DATE  
OF  
DEATH

March 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Maryland

D. STREET ADDRESS (If rural, give location)

3711 Barrington Road

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3711 Barrington Rd.

Yrs.  
Mos.  
Days

Length of stay in Baltimore 50 years

SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

12-24-1887

9. AGE (in years last birthday)

62 63

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Teacher

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Baltimore, County Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Josiah W. Bowen

14. MOTHER'S MAIDEN NAME

Eleanor Hissey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Myrtle I. Bowen 3711 Barrington Rd.

18. 33 4X I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Degenerative Encephalitis

5 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Asthenia

6 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Oct 14, 1950, to Incl 24, 1950 that I last saw the deceased alive on Incl 24 1950, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-27-50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

E. J. Spaworth Dermacost

5118 Gwynn Oak Ave.

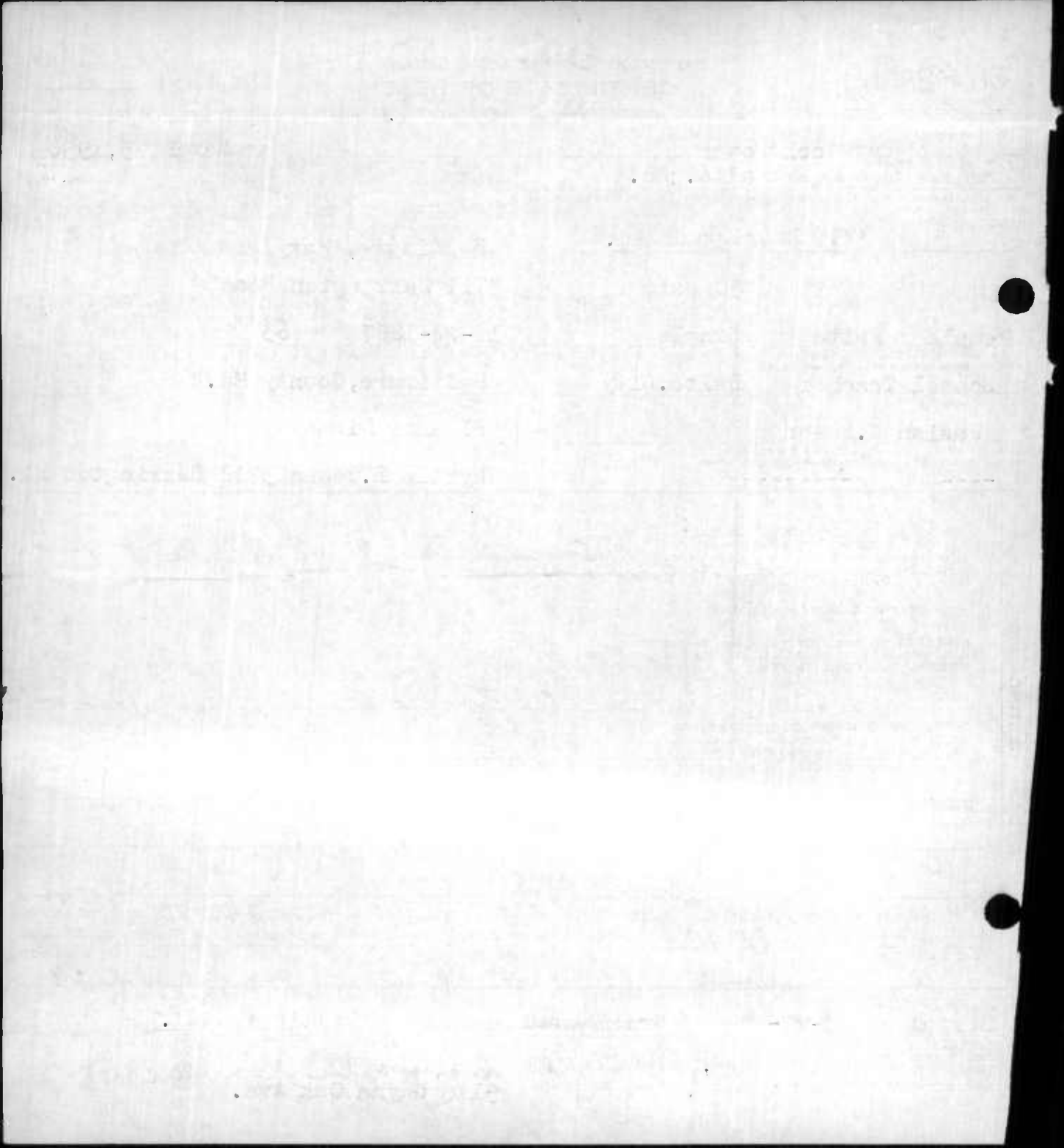
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V3491

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MEDICAL CERTIFICATION







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2896

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

BLANCHE E. REYNOLDS

2. DATE OF DEATH Mar. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Kirkleigh Villa  
4301 Roland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTY Cecil

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Rising Sun

D. STREET ADDRESS (If rural, give location)  
-

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX female 6. COLOR OR RACE white 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow 8. DATE OF BIRTH Mar. 29, 1873 9. AGE (In years last birthday) 76

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10B. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George C. Minor

14. MOTHER'S MAIDEN NAME

Lucy Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. -

17. INFORMANT ADDRESS Silver Spring, Md  
Mr. Ralph E. Reynolds - 10103 McKenny Ave

18. *4221*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from Jan 10 to March 10, 1950, that I last saw the deceased alive on 3/20/50 and that death occurred at 10:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/29/50

Brookview Cem.

Rising Sun, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

William J. Tickner & Sons

WM. J. TICKNER & SONS

Balto., Md.



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		Jan 15, 1950	
Place of Birth		Date of Birth		Cause of Death		Manner of Death		Occupation	
New York City		Jan 1, 1905		Heart Disease		Natural		Teacher	
Residence at Time of Death		Date of Death		Time of Death		Place of Death		Physician	
123 Main St, New York		Jan 15, 1950		10:00 AM		Home		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal		Official Seal		Official Seal	
Jan 16, 1950		New York City		[Seal]		[Seal]		[Seal]	











BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2898

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Priscilla Freeman (Freeland)*

2. DATE  
OF  
DEATH

*March 26, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

*md*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto*

*16-03*

D. STREET ADDRESS (If rural, give location)

*1006 1/2 Vincent St*

5. DATE OF BIRTH

*1876*

9. AGE (In years last birthday)

*73*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

14. MOTHER'S MAIDEN NAME

*unobtainable*

Length of stay in Baltimore

SEX

*F*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*W*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*none*

10B. KIND OF BUSINESS OR INDUSTRY

*none*

13. FATHER'S NAME

*unobtainable*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL SECURITY NO.

*none*

17. INFORMANT

*Bernice Moore*

ADDRESS

*1109 1/2 Fulton Ave*

18. *332 X 1*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) *Cerebral thrombosis*

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *3-9-50* 19, to *3-26-50*, that I last saw the deceased alive on *3-26-50*, and that death occurred at *10:25* a.m., from the causes and on the date stated above.

23A. SIGNATURE

*Lucy C. Freeman*

23B. ADDRESS

*1109 1/2 Fulton Ave*

23C. DATE SIGNED

*3-26-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/30/50*

24C. NAME OF CEMETERY OR CREMATORY

*Int Auburn*

24D. LOCATION (City, town, or county) (State)

*md*

DATE RECEIVED BY LOCAL REGISTRAR

*MAR 28 1950*

REGISTRAR'S SIGNATURE

*Huntington Williams*

25. FUNERAL DIRECTOR

*Heard & Nelson*

ADDRESS

*1303 President St*



Handwritten text at top left, possibly a date or reference number.

(Printed) text at top center.

Handwritten word, possibly "and".

Handwritten word, possibly "about".

Handwritten phrase, possibly "1000 ...".

Handwritten numbers, possibly "1000" and "1000".

Handwritten word, possibly "Thompson".

Handwritten phrase, possibly "about 1000".

Handwritten phrase, possibly "about 1000".

Handwritten phrase, possibly "about 1000".

Handwritten word, possibly "are".

Large handwritten text at the bottom, possibly a signature or date.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2899

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE  
OF  
DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give  
Township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 174X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma uteri

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

22. I hereby certify that I attended the deceased from 8/24 1949, to 3/26 1950, that I last saw the  
deceased alive on 3/26 1950, and that death occurred at 8:05 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

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FORM NO. 104-100

WALSH  
COLEMAN  
BONAC  
COLEMAN



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2900

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Francis Sneed</i>			2. DATE OF DEATH <i>3-25-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>38 Univ. Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 21-02</i>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1443 W. Hamburg St</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/25/1894</i>	9. AGE (in years last birthday) <i>56</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>Sam Carroll</i>			14. MOTHER'S MAIDEN NAME <i>Rachael Carroll</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs. Leslie Smith(S)</i>			ADDRESS <i>1317 Bayard St.</i>		

18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Generalized Arteriosclerosis</i> DUE TO <i>Arteriosclerotic C.V.D.</i> (B) <i>Pulmonary Congestion &amp; Edema</i> DUE TO <i>Hepatic Cirrhosis</i> (C) <i>Coronary</i>	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>2</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3-17*, 19*50*, to *3-25*, 19*50*, that I last saw the deceased alive on *3-25*, 19*50*, and that death occurred at *2:30* A. M., from the causes and on the date stated above.

23A. SIGNATURE <i>R. G. Cooper</i>	23B. ADDRESS <i>Univ. Hosp.</i>	23C. DATE SIGNED <i>3-25-50</i>
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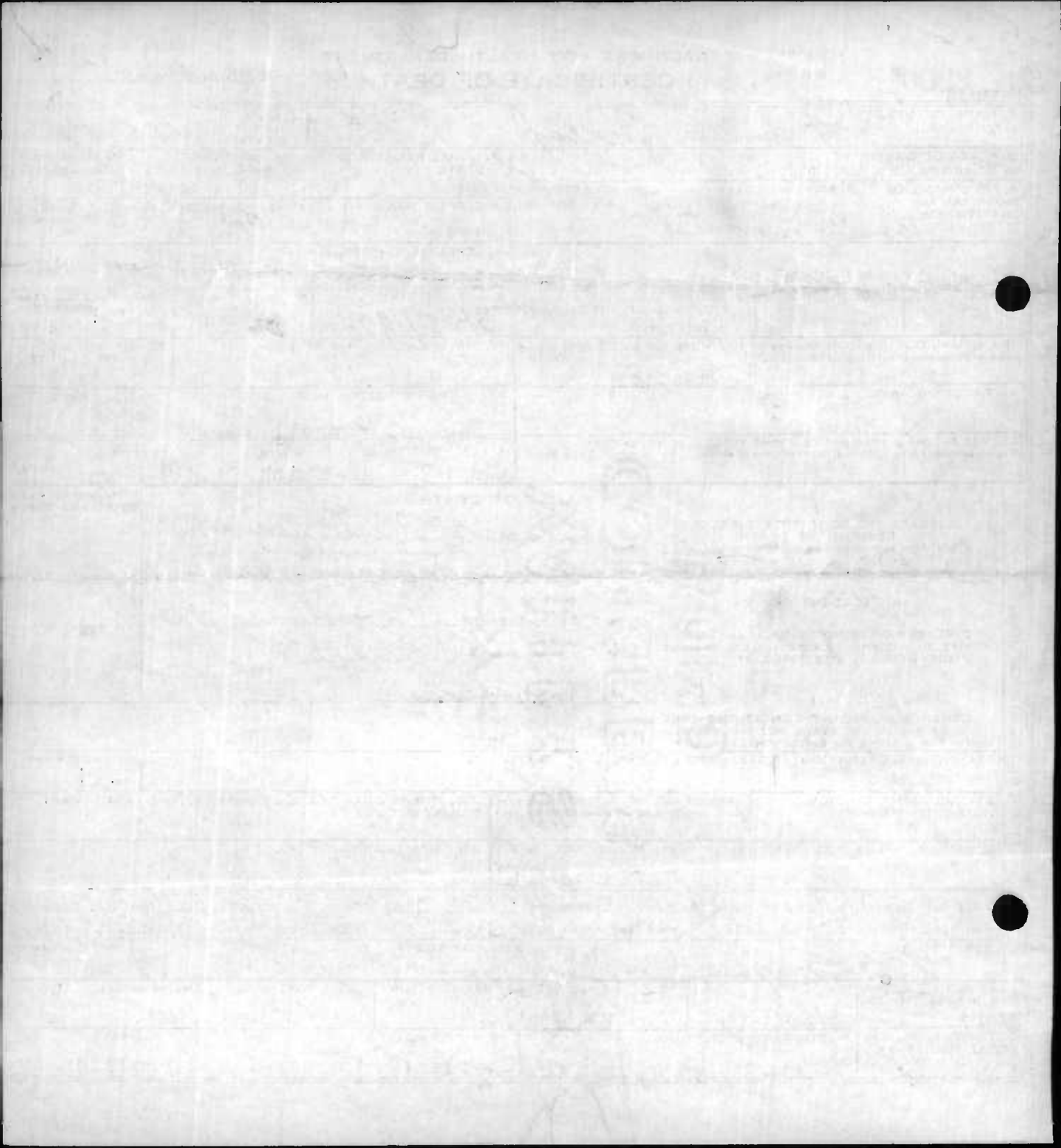
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/29/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem'l. Pk</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. County, Md.</i>
--	-----------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 28 1950</i>	REGISTRAR'S SIGNATURE <i>William H. ...</i>	25. FUNERAL DIRECTOR <i>Charles G. Cooper</i>	ADDRESS <i>512 Carrollton Av.</i>
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VS 150

124B







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2901  
Registered No.

BIRTH NO. 2901

1. NAME OF DECEASED (Type or Print) <b>George Edward William Teves</b>		2. DATE OF DEATH <b>Mar. 26, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>St. Joseph's Hospital (DOR)</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 8-07</b>	
D. STREET ADDRESS (If rural, give location) <b>1237 North Broadway</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>April 29 1911 38</b>
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) <b>Handyman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Rustless Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
13. FATHER'S NAME <b>William E. Teves</b>		14. MOTHER'S MAIDEN NAME <b>Edna Marie Parlett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-05-7681</b>	
		17. INFORMANT <b>2134 E. Oliver St Mrs Edna Marie Ponzillo</b>	
12. CITIZEN OF WHAT COUNTRY?			

18. <b>E 977</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carbon Monoxide Poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1237 N. Broadway</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>3/26/50 8:30 A. m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Gas stove on but unlit</b>
22. I certify that I took charge of the remains described above, held an <b>Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <b>Wm. H. Kammer</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR..... <b>Mgr. 26, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Mar. 29, 50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>2 H? Sander &amp; Sons Inc. Balto. Md.</b>

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N-918

98841

163H



CERTIFICATE OF DEATH

1912

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620  
50 2902BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2902

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY CLARICE BERSCH

2. DATE  
OF  
DEATH

3/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MARYLAND

B. COUNTY

BALTIMORE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

TOWSON

D. STREET ADDRESS (If rural, give location)

212 WASHINGTON AVE.

Length of stay in Baltimore

YRS.

Yrs.  
Mos.  
Days

SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

APRIL 21, 1889

9. AGE (In years  
last birthday)

60

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

TEACHER

10B. KIND OF BUSINESS OR  
INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN C. BERSCH

14. MOTHER'S MAIDEN NAME

VIRGINIA DUNKUM

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

DR. ANITA DOWELL

ADDRESS

CAMBRIDGE ARMS APTS

18. 175X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Generalized peritonitis

DUE TO

days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Perforation of small bowel

DUE TO

days

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Generalized abdominal/Concinnomatosi  
Concinnomatosi of pelvic organs (ovary)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/16, 1950, to 3/27, 1950, that I last saw the  
deceased alive on 3/27, 1950, and that death occurred at 3:30 pm., from the causes and on the date stated above.

23A. SIGNATURE

Dr. F. Cox 34

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

3-27-50

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Mar 29-50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

Huntington Williams

John R. Cox 4

VS 150

V3491

49a



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Signature of Coroner		Signature of Medical Examiner	
Signature of Burial Officer		Signature of Cemetery Officer	
Signature of Undertaker		Signature of Funeral Home	
Signature of Family		Signature of Friends	
Signature of Church		Signature of Community	
Signature of State		Signature of Nation	



600  
50 2903

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2903  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John B. Mann</i>		2. DATE OF DEATH <i>Mar-26-1950</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland <i>2314 E. Preston St</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>8-04</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
Length of stay in Baltimore Yrs. <i>00</i> Mos. <i>00</i> Days <i>00</i>		D. STREET ADDRESS (If rural, give location) <i>2314 E. Preston St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb-24-1890</i>
9. AGE (In years last birthday) <i>60 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Donrad Mann</i>		14. MOTHER'S MARDEN NAME <i>Elizabeth Heigelmeier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-10-7737</i>	
17. INFORMANT <i>Anna Moller - 2314 E. Preston St</i>		ADDRESS	

18. <i>4428</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Penetration</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
DUE TO <i>Cardio Vascular Renal Disease</i>		<i>2 1/4 yrs</i>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>0</i>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>0</i>		
19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION <i>0</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>0</i>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>0</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>0</i>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>0</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <i>0</i>	21F. HOW DID INJURY OCCUR? <i>0</i>

2. I hereby certify that I attended the deceased from *February 13, 1948* to *March 26, 1950*, that I last saw the deceased alive on *March 25, 1950*, and that death occurred at *5:10 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Albert Eisenberg</i>	23B. ADDRESS <i>2025 East North Ave</i>	23C. DATE SIGNED <i>March 27, 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-29-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	25. FUNERAL DIRECTOR <i>John B. Miller Inc - 2435 E. Oliver St</i>	

DATE RECEIVED BY LOCAL REGISTRAR  
*MAR 28 1950*

REGISTRAR'S SIGNATURE  
*Huntington Williams*

VS 150  
*V 2693*

131a

MEDICAL CERTIFICATION



Dr. Eisenberg



50 2904

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2904

Registered No.

1. NAME OF DECEASED (Type or Print) <b>LAWRENCE F. W. PLUMHOFF</b>		2. DATE OF DEATH <b>March 25, 1950.</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>505 S. Robinson St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>1-02</b>	
D. STREET ADDRESS (If rural, give location) <b>505 S. Robinson St.</b>		8. DATE OF BIRTH <b>December 29, 1891</b> <b>58</b>	
9. AGE (In years; last birthday)		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Muth Bros. Drug Co.</b>		13. FATHER'S NAME <b>Henry Plumhoff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary A. Plumhoff</b>		ADDRESS <b>505 S. Robinson St.</b>	

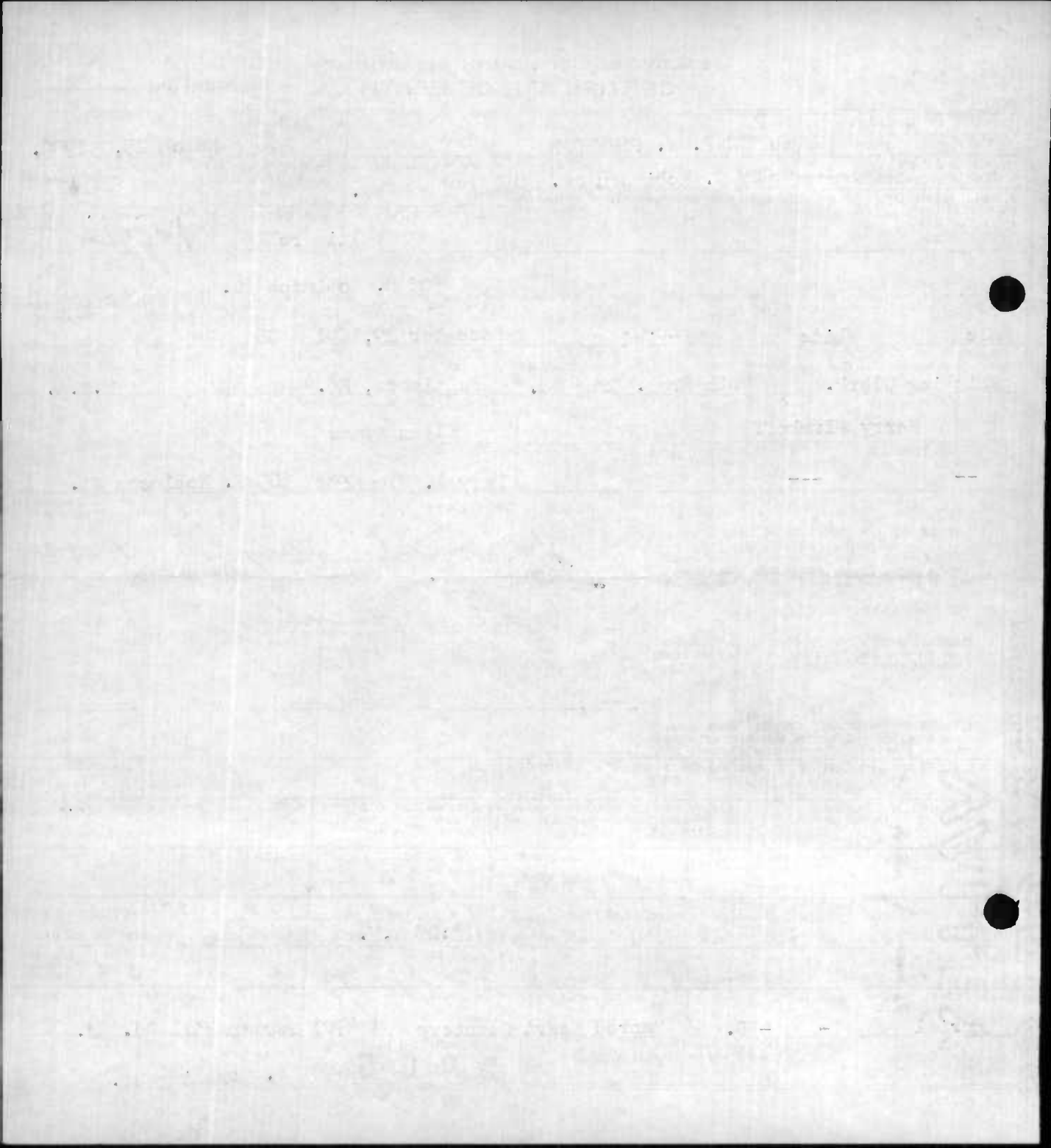
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertension (C.V. Disease)</b> DUE TO <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-23-50</b> <b>3-23-50</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>none</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>	

2. I hereby certify that I attended the deceased from **3-23, 1950**, to **3-25, 1950**, that I last saw the deceased alive on **3-24, 1950**, and that death occurred at **8:25 A.M.** from the causes and on the date stated above.

23A. SIGNATURE <b>E. Schumacher</b>		23B. ADDRESS <b>842 S. East Ave</b>		23C. DATE SIGNED <b>3-27-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3- -50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>4701 German Hill Rd. Md.</b>		25. FUNERAL DIRECTOR <b>Charles S. Fisher</b>		ADDRESS <b>901 S. Conkling St.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 28 1950</b>		REGISTRAR'S SIGNATURE <b>Anthony J. [Signature]</b>			







361  
50 2905

50 2905

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

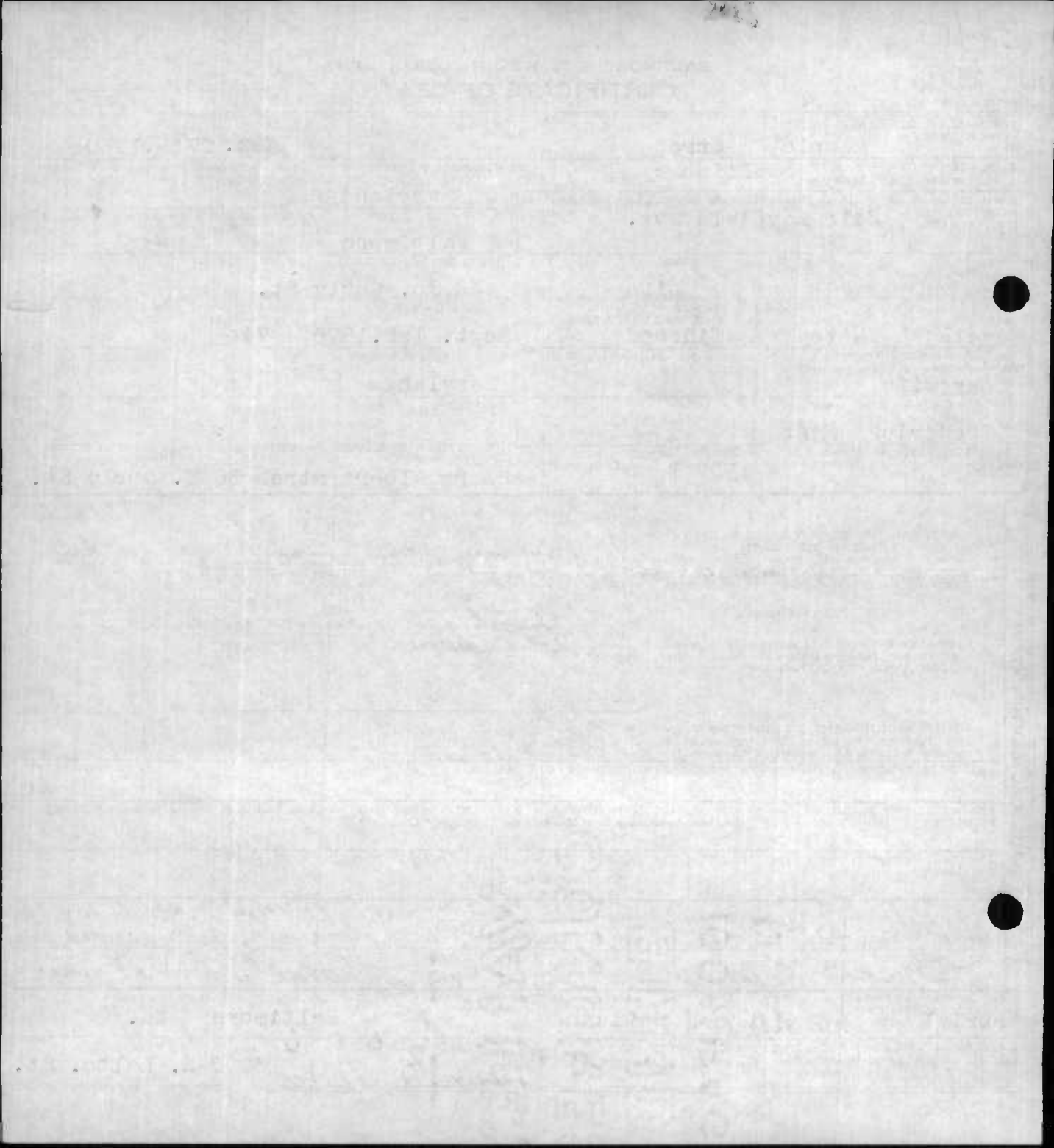
1. NAME OF DECEASED (Type or Print) <b>Minnie Streb</b>		2. DATE DEATH <b>Mar. 27th. 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>3413 Mayfield Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>1-02</b>	
6. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>36 So. Curly St.</b>	
7. SEX <b>Female</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	10. DATE OF BIRTH <b>Sept. 1st. 1875</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick Herz</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Henry Albert Streb</b>		ADDRESS <b>36 S. Curly St.</b>	

MEDICAL CERTIFICATION

18. <b>470.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive arteriosclerosis without disease</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Obesity</b>		CAUSE OF DEATH <b>Coronary thrombosis</b> <b>Hypertensive arteriosclerosis without disease</b> <b>Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>a hr</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>27 Mar</b> , 19 <b>50</b> , to <b>27 Mar</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>27 Mar</b> , 19 <b>50</b> , and that death occurred at <b>4:15</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>W. B. Cape Jr.</b>		23B. ADDRESS M. D. <b>2843 St Paul St</b>		23C. DATE SIGNED <b>28 Mar 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar. 30, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		24E. NAME OF FUNERAL DIRECTOR <b>John A. Moran</b>		24F. ADDRESS <b>3000 E. Balto. St.</b>	

937







450  
2906BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2906

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Margaret Mary Moylan

2. DATE

OF  
DEATH Mar. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1317 Aisquith St

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

9-09

D. STREET ADDRESS (If rural, give location)

1317 Aisquith St

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 1863

9. AGE (In years,  
last birthday)

86

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Children's Nurse

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF  
WHAT COUNTRY?

U S

13. FATHER'S NAME

Cornelius Moylan

14. MOTHER'S MAIDEN NAME

Ellen Mullane

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Moylan 1317 Aisquith St

18. 443 x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

Cerebral Hemorrhage 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

Hypertensive - Cerebro-Vascular  
Disease

DUE TO

(C) ...

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 10, 1950, to March 24, 1950, that I last saw the  
deceased alive on March 24, 1950, and that death occurred at 11:00 P. M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 29/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL OFFICE

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

Wilmington, Delaware, Md

Rita W. DeLoe 970 E. Biddle St



RECEIVED

U.S. S. V. 1002-540  
FOND

CONGREGATION

WATER

WATER

U.S. S. V. 1002-540

WATER

U.S. S. V. 1002-540



416  
50 2907

Albrecht

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2907

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Charles Albrecht</i>		2. DATE OF DEATH <i>March 27, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore 10-01</i>	
D. STREET ADDRESS (If rural, give location) <i>1200 Valley St</i>		5. LENGTH OF stay in Baltimore Yrs. _____ Mos. _____ Days _____	
6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W.</i>	8. DATE OF BIRTH <i>July 11, 1879</i>	9. AGE (In years last birthday) <i>70</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Iron works</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Iron worker</i>	
11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>W. Albrecht</i>		14. MOTHER'S MAIDEN NAME <i>Roosina Guas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Little Sisters of the Poor</i>		ADDRESS <i>1200 Valley St</i>	

18. <i>422.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <i>Edema Lungs</i> <i>Chronic Myocarditis</i>  (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yr</i>
--	---	---

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> ND <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>Mar 1 -</i> , 1950, to <i>Mar 27 -</i> , 1950, that I last saw the deceased alive on <i>Mar 27, 1950</i> , and that death occurred at <i>12:20 P. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>E. Gill Hall M.D.</i>		23B. ADDRESS <i>1631 E North Ave</i>		23C. DATE SIGNED <i>Mar 28 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 29/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 28 1950</i>		24F. REGISTRAR'S SIGNATURE <i>W. H. Williams</i>	
24G. FUNERAL DIRECTOR <i>Rita Wiedefeld</i>		24H. ADDRESS <i>900 E. Biddle St</i>		24I. _____	



CONFIDENTIAL

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

VALLEY  
CONFIDENTIAL  
RECORDS  
100%

[Faint text at the bottom of the page, possibly a signature or footer.]



543  
50 2908BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2908  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annice Donaldson

2. DATE  
OF  
DEATH

3/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

D.O.A. Md. GENL. Hosp.

4 Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md.

City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 17-01

D. STREET ADDRESS (If rural, give location)

815-Penna. Ave.

Length of stay in Baltimore

SEX

F.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 4, 1900

9. AGE (In years  
last birthday)

49

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of work life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

Laundry

13. FATHER'S NAME

Edward Seldon

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, and as unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

224-18-2461

17. INFORMANT

ADDRESS

Robert Donaldson - 815-Penna. Ave.

18. 490 x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Lobar pneumonia

DUE TO

3 wks

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Royer

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

19 Mar 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/30/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington, N.Y. 11750

25. FUNERAL DIRECTOR

ADDRESS

B. J. Galstead - 918-

Alfred Hill Ave.

MAR 28 1950  
VS151

108







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 2909**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **MARGARET M. RAMSEY**

2. DATE OF DEATH **March 23, 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**University Hospital**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**210 W. Pleasant Street**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX  
**Female**

6. COLOR OR RACE  
**colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Single**

8. DATE OF BIRTH

**June 25, 1945**

9. AGE (in years last birthday)

**4**

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

**infant**

10B. KIND OF BUSINESS OR INDUSTRY

**infant**

11. BIRTHPLACE (State or foreign country)

**N. C.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Joe William Ramsey**

14. MOTHER'S MAIDEN NAME

**Alice Forrest**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

**none**

17. INFORMANT

**Joe Wm. Ramsey - Pleasant St.**

Address

18. **491X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Upper respiratory infection with early bronchopneumonia**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Dr. J. Mc Clafferty**

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

**March 23, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Shipped**

24B. DATE

**3/30/50**

24C. NAME OF CEMETERY OR CREMATORY

**Seaboard, N. C.**

24D. LOCATION (City, town, or county)

**206 W. Halstead - 918 -**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**MAR 28 1950**

REGISTRAR'S SIGNATURE

**Thurston H. V. ...**

25. FUNERAL DIRECTOR

**206 W. Halstead - 918 -**

ADDRESS

**David Hill, 109 Ave.**







452  
50 2910BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2910

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)(LOWDEN)  
Alice Williams2. DATE  
OF  
DEATH

March 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

153 Winters Ave.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 578X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) Undiagnosed Disease  
DUE TO characterized by vomiting  
(B) dehydration and shock  
DUE TO  
(C)INTERVAL BETWEEN  
ONSET AND DEATH

3 weeks

new

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25, 1950 to 3-25, 1950, that I last saw the  
deceased alive on 3-25, 1950, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3-26-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

52086

120B



Ulceration of ileum (50-2910-5/4/50.) Letter in document file.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2911  
Registered No. \_\_\_\_\_

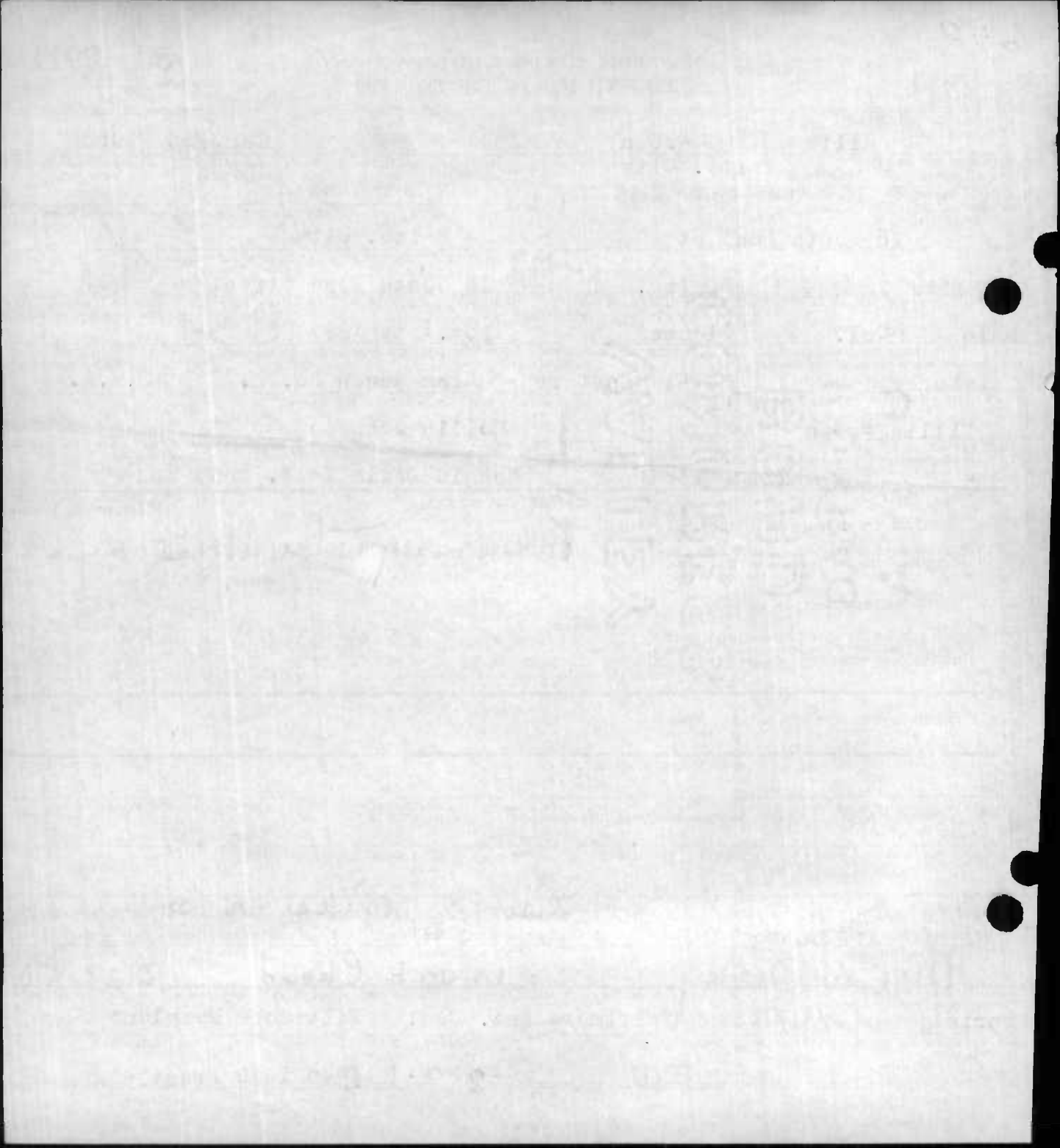
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Allie Brown</b>		2. DATE OF DEATH <b>3/26 /1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>15 South Bond St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. City 3-01</b>	
D. STREET ADDRESS (If rural, give location) <b>15 South Bond Street</b>		E. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
F. LENGTH OF STAY IN BALTIMORE <b>30 Yrs.</b>		G. STREET ADDRESS (If rural, give location)	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 15th 1897</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Mutal Sanatary</b>	9. AGE (In years last birthday) <b>52</b>
13. FATHER'S NAME <b>Allie Brown</b>		11. BIRTHPLACE (State or foreign country) <b>King Queen Co. Va.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes War # I</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Mollie Johnson</b>	
17. INFORMANT <b>Maggie Lewis</b>		ADDRESS <b>15 S. Bond St</b>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
DUE TO (A) _____		
DUE TO (B) _____		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Mar. 14, 1950</b> to <b>Mar. 26, 1950</b> , that I last saw the deceased alive on <b>Mar. 26, 1950</b> and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Wm. L. Derry</b>		23B. ADDRESS <b>1430 E. Chase</b>		23C. DATE SIGNED <b>3-28-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/31/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat. Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		25. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 28 1950</b>		REGISTRAR'S SIGNATURE <b>Therese J. Pappalardo</b>			







# CERTIFICATE CORRECTED 4-14-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

50 2912

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Andrew Lee Braham- BRANHAM

2. DATE  
OF  
DEATH

3-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

Baltimore

5-200

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

County

None

D. STREET ADDRESS

(If rural, give location)

2415 Caroline Ave.-19 Balto., Co.,

Length of stay in Baltimore

25 yrs.

Yrs.  
Mos.  
Days

EX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Feb. 22, 1888

9. AGE (In years

last birthday)

62 63-4

10. Under 1 Year

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Owner

10B. KIND OF BUSINESS OR INDUSTRY

BETH STEEL CO.

13. FATHER'S NAME

(D)

SHIPYARD

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF

WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

(D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. 443 X I

### CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intraventricular hemorrhage

DUE TO

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive arteriosclerotic cardiovascular disease

DUE TO

### II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-25-50, 19, to Mar. 27, 19 50 that I last saw the deceased alive on Mar. 27, 19 50, and that death occurred at 3:25 PM from the causes and on the date stated above.

23A. SIGNATURE

W. H. O. J. Fisher

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

3-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

MARCH 30, 1950

WILHOIT PR. CEM. ALDERMARLE CO., VA.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 28 1950

ROLAND F. FISHER

DUNDAS

VS 150

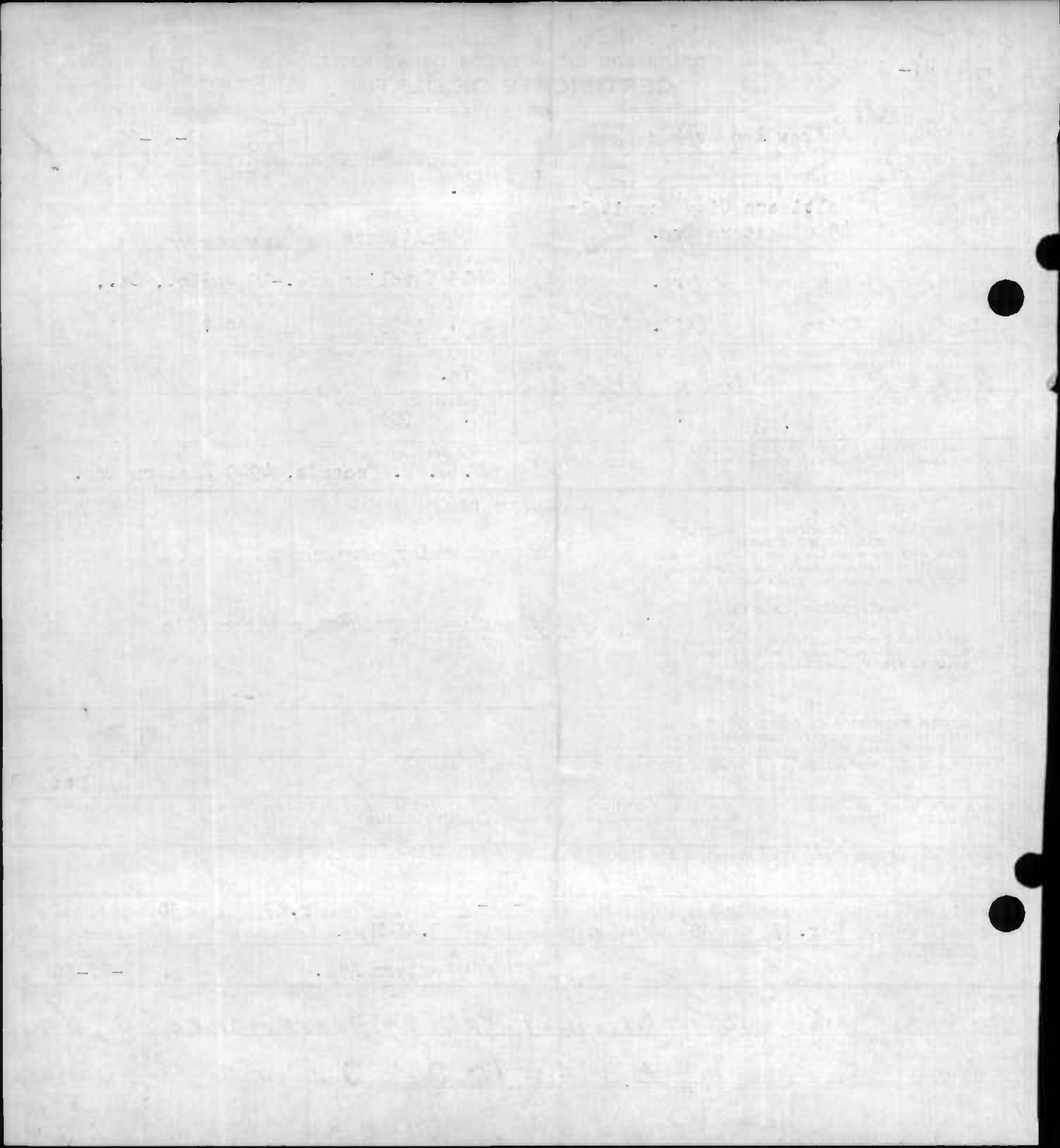
4844V

93D Mo.

Medical Certification: Please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION







# CERTIFICATE CORRECTED 4-5-50

50 2913

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2913

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JESSIE L. BALLANTYNE</b>		2. DATE OF DEATH <b>Mar. 25, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Kenosaw Nursing Home</b> <b>2601 Roslyn Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>5510 Windsor Mill Rd.</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>	8. DATE OF BIRTH <b>July 29, 1867</b>
9. AGE (In years: last birthday) <b>82</b>	10. BIRTHPLACE (State or foreign country) <b>Scotland</b>	11. CITIZEN OF WHAT COUNTRY? <b>Scotland</b>	
12. FATHER'S NAME <b>Peter Lyall</b>		13. MOTHER'S MAIDEN NAME <b>Elizabeth Allen</b>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		15. SOCIAL SECURITY NO. <b>212-07-2026</b>	
16. INFORMANT <b>Gabrielle</b>		17. ADDRESS <b>5510 Rd. Woodlawn</b>	
18. MRS. GABRIELLA SLATOR		19. ADDRESS <b>3510 Windsor Mill</b>	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

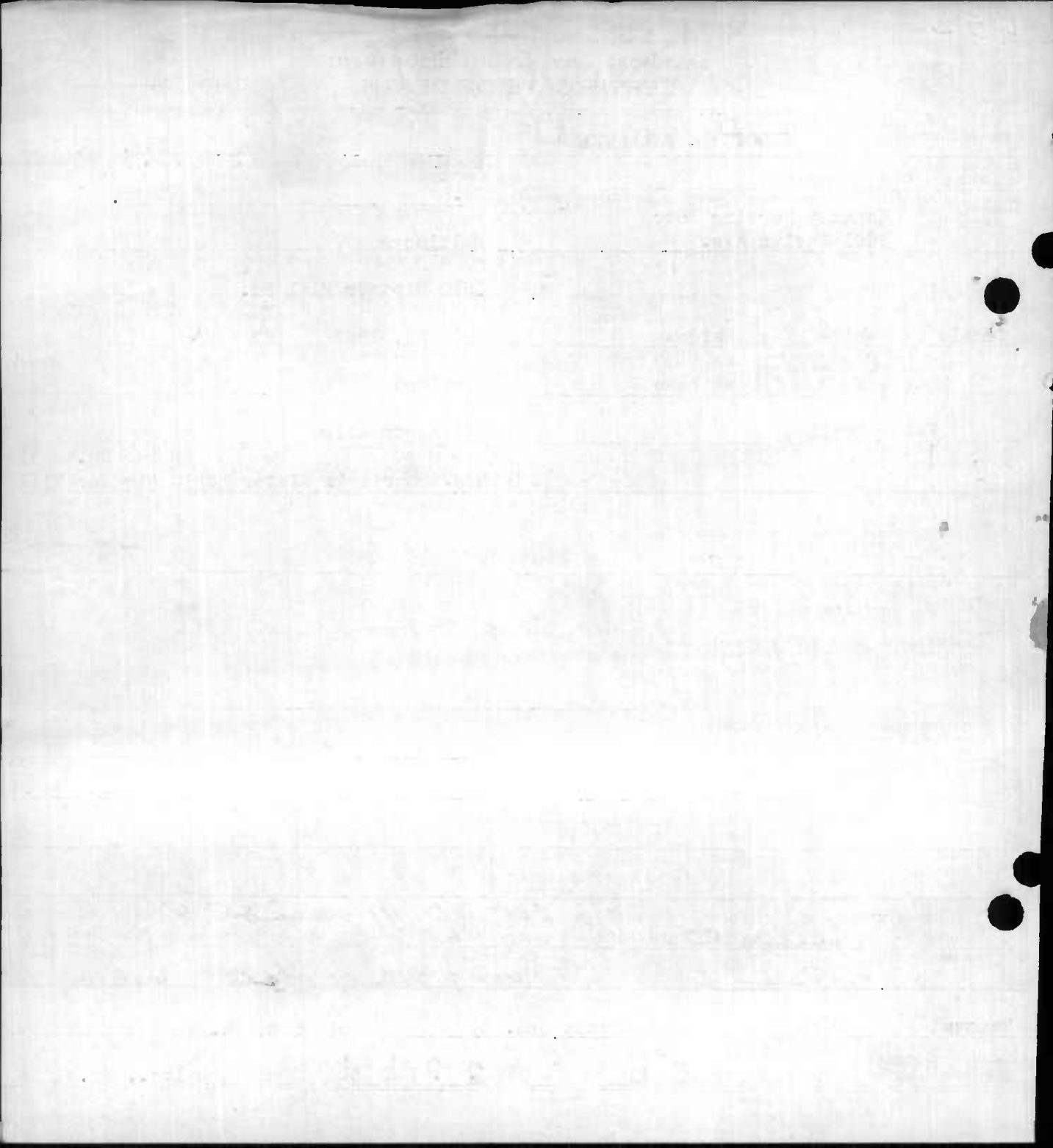
22. I hereby certify that I attended the deceased from **Oct 30, 1949**, to **March 25, 1950** that I last saw the deceased alive on **March 24, 1950**, and that death occurred at **4 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>A. C. Smith</b>	23B. ADDRESS <b>4109 Liberty Hill</b>	23C. DATE SIGNED <b>Mar 28</b>
--------------------------------------	--	-----------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>3/28/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Bethesda Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Holtwood, Pa.</b>
---	-----------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR <b>BAR 28 1950</b>	REGISTRAR'S SIGNATURE <b>A. C. Smith</b>	25. FUNERAL DIRECTOR <b>J. P. Tickner &amp; Sons</b>	ADDRESS <b>Balto., Md.</b>
--	---	---	-------------------------------







262  
50

2914

ARTHUR ROGERS  
BALTIMORE CITY HEALTH DEPARTMENT

X 50 2914

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rogers Arthur

2. DATE  
OF  
DEATH

3.28.1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Doctors Hospital

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

49

Doctors Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Linthicum Heights

5200

D. STREET ADDRESS (If rural, give location)

Hawthorne Rd

Length of stay in Baltimore

EX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

6-9-1891

9. AGE (in years  
last birthday)

38

H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Inspector of Customs U.S. Gov.

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York City N.Y.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

FRANK Rogers

14. MOTHER'S MAIDEN NAME

Alice Tobaz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or name of service)

Yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ella M. Rogers, Linthicum

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary thrombosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to March 28, 1950, that I last saw the  
deceased alive on 3/28, 1950, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Daworski

M. D.

23B. ADDRESS

2711 Canton Ave

23C. DATE SIGNED

3/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

National

24D. LOCATION (City, town, or county)

Baltimore MD

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

William J. Daworski 1217 St Paul



CONFIDENTIAL



400  
50 2915BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 2915

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY D. HILL

2. DATE  
OF  
DEATH

Mar. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

2700 Boone St.

Baltimore

D. STREET ADDRESS (If rural, give location)

2700 Boone St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Dec. 14, 1876

9. AGE (in years  
last birthday)

73

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Lineman retired

10B. KIND OF BUSINESS OR  
INDUSTRY

C.&amp;P. Tel Co

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Hill

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charles Hill, 2700 Boone St.

18. 442X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Chronic Myocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Cardio-  
vascular Renal Disease

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐2. I hereby certify that I attended the deceased from Feb. 3, 1950, to Mar. 27, 1950, that I last saw the  
deceased alive on Mar. 27, 1950, and that death occurred at 3:29 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/30/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Baltimore Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

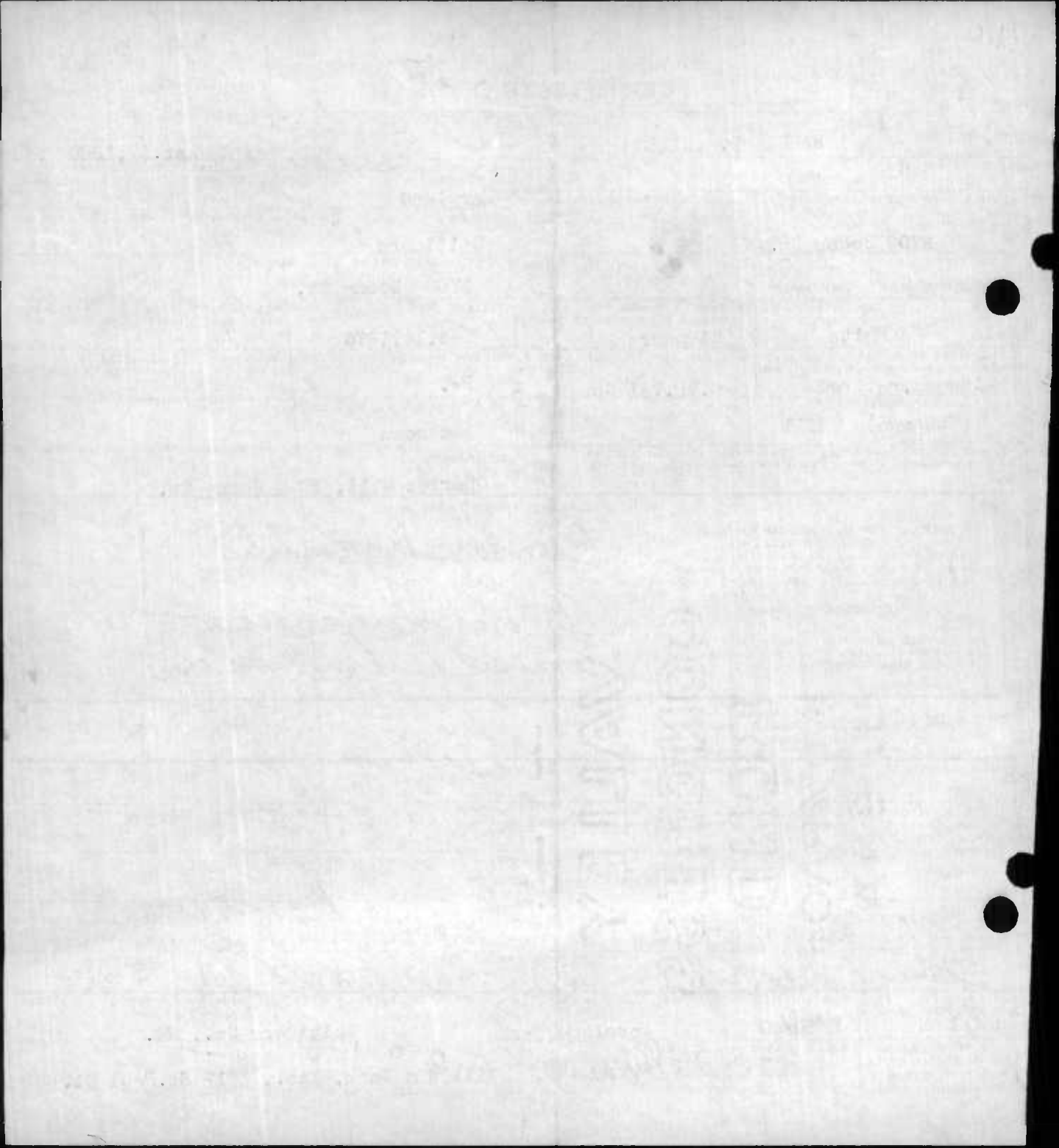
ADDRESS

MAR 29 1950

Huntington Williams

William Cook, Inc., 1217 St. Paul St.







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **Mary Virginia Felter** 2. DATE OF DEATH **Mar 27-1950**

3. PLACE OF DEATH: A. Baltimore City, Maryland **5713 Pimlico Road** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Md** COUNTY **Balto**

B. FULL NAME OF HOSPITAL OR INSTITUTION **00** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Lutherville**

D. STREET ADDRESS (If rural, give location) \_\_\_\_\_

Length of stay in Baltimore **6 Mos** Yrs. Mos. Days

EX **F** 6. COLOR OR RACE **W** 7. ~~SINGLE-MARRIED~~ **WIDOWED, DIVORCED** (Specify) 8. DATE OF BIRTH **Cet 27-1870** 9. AGE (In years last birthday) **79** 11 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY **Home** 11. BIRTHPLACE (State or foreign country) **Baltimore Co. Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **Noah Martin** 14. MOTHER'S MAIDEN NAME **Rebecca Fishpaw**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT ADDRESS **Mrs Mae Barrett, Lutherville, Md**

18. **420.1** CAUSE OF DEATH **Coronary Sclerosis** INTERVAL BETWEEN ONSET AND DEATH **10-15 yrs**  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO **4** **Stenosis** **Sudden**

ANTECEDENT CAUSES (B) \_\_\_\_\_ DUE TO \_\_\_\_\_

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. \_\_\_\_\_

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION **✓** 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) **No** 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **✓** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **✓**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? **✓**

22. I hereby certify that I attended the deceased from **10-15 yrs**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on **3/14**, 19**50**, and that death occurred at **3:19** p.m., from the causes and on the date stated above.

23A. SIGNATURE **James J. Carroll** 23B. ADDRESS **3908 Kromer Rd.** 23C. DATE SIGNED **3/28/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Mar 30-1950** 24C. NAME OF CEMETERY OR CREMATORY **Druid Ridge** 24D. LOCATION (City, town, or county) (State) **Pikesville, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **MAR 29 1950** REGISTRAR'S SIGNATURE **Wm. J. Williams, M.D.** 25. FUNERAL DIRECTOR **John Burns Sons** ADDRESS **610 York Road, Towson 4**

VS 150 **2917** **94a**

MEDICAL CERTIFICATION

cause, while the causes of death clearly and leg



CERTIFICATE OF DEATH

19-10-1950

19-10-1950

19-10-1950

19-10-1950

19-10-1950

19-10-1950

19-10-1950

19-10-1950

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19-10-1950

19-10-1950



540  
50 2917BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2917  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lucy L. Hunley

2. DATE  
OF  
DEATH

Mar 28-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3502 Fairview Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Balto

B. COUNTY Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 15-38

D. STREET ADDRESS (If rural, give location)

3502 Fairview Ave.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOWED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

Sept-5-1874

9. AGE (In years last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Gloucester Co., Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

W.R.B. Hunley

14. MOTHER'S MAIDEN NAME

Susan Lane

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
None

17. INFORMANT

ADDRESS

Alfred S. Hunley 607 Somerset Rd. 10

18.

154X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma Rectum

3 1/2 yrs

DUE TO

metastases with  
metastases

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1st, 1945, to 28 Mar, 1950, that I last saw the deceased alive on 28 Mar, 1950, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

3033 W North Ave

8/18/50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Mar 30-1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county) (State)

Pikesville, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

2224 N. Charles

VS 150

49c



STATE OF TEXAS

1907

1907

1907

1907

1907

1907

1907

1907

1907



352

50 2918

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2918  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ida V. Keating

2. DATE  
OF  
DEATH

March 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

4802 Althea Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

township)

Baltimore

26-02

D. STREET ADDRESS (If rural, give location)

4802 Althea Ave.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

SEX

F

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/16/60

9. AGE (In years

last birthday)

89

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John P. Keating

14. MOTHER'S MAIDEN NAME

Sarah J. Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

No

17. INFORMANT

ADDRESS

Sadie Weggel 4804 Althea Ave.

18. 592X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Chronic Myocarditis

1940

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Subacute Nephritis

1940

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Feb 24, 1950, to Mar 27, 1950, that I last saw the  
deceased alive on Mar 26, 1950, and that death occurred at 2:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Dane Brown

23B. ADDRESS

1663 W. North E.

23C. DATE SIGNED

3-28-50

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

J. T. Stansbury 2700 Edmondson Ave.

VS 150

131a

MEDICAL CERTIFICATION



STATE OF CALIFORNIA  
CERTIFICATE OF DEATH

THE DECEASED WAS

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF INCINERATION

NAME OF BURIAL

NAME OF CREMATION



500  
50 2919BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2919  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Frederick Cuno</b>		2. DATE OF DEATH <b>3-25-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>4206 Wilshire Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Md. 26-01</b>	
D. STREET ADDRESS (If rural, give location) <b>4206 Wilshire Ave.</b>		8. DATE OF BIRTH <b>3-7-1860</b>	
9. AGE (In years, last birthday) <b>90</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Work</b>		12. CITIZEN OF WHAT COUNTRY?	
10B. KIND OF BUSINESS OR INDUSTRY <b>U.B.F.G.</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		17. INFORMANT ADDRESS <b>Pauline Doemer 3307 Noble Street</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO.	

18. **416X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

(A) **carditis**  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

**3 yrs.**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **chronic arthritis**  
DUE TO

!

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **caduxia hypertension**19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from **March 14, 1950**, to **March 25, 1950**, that I last saw the deceased alive on **March 24, 1950**, and that death occurred at **1:30 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE

**L C. Doherty M.D.**

23B. ADDRESS

**447 N. Kenwood Ave.**

23C. DATE SIGNED

**3/28/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**3-29-50**

24C. NAME OF CEMETERY OR CREMATORY

**Loudon Park**

24D. LOCATION (City, town, or county) (State)

**Baltimore Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Livingston Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**Edesworth Remacost**



STANDARD FORM NO. 64

U. S. A.

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1941

1941

SECRETARY

1941

THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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50 2920

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2920  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lilly Gertrude Sapp

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1080 W. Fairmount Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1080 W. Fairmount Ave.

6. COLOR OR RACE

Female

Colore

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

Feb. 10, 1895

9. AGE (In years  
last birthday)

55

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

M's Alice Williams 1080 Fairmount

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive cardio-vascular  
disease

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Hemiplegia. Emaciation

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 3-24, 1950, to 3-26, 1950, that I last saw the  
deceased alive on 3-26, 1950, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

C. P. Campbell

23B. ADDRESS

718 Dolphin St.

23C. DATE SIGNED

3-28-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3-29-50

Mt. Auburn Cem

Baltimore, Md.

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 29 1950

Huntington Williams, M.D.

Mrs. Frances A. Hemsley

578 W. Biddle St.







50 2921

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2921

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph Bridges

2. DATE  
OF DEATH March 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

536 Moore St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 17-01

D. STREET ADDRESS (If rural, give location)

536 Moore St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 8, 1882

9. AGE (In years last birthday)

67

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

General

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Bridge

14. MOTHER'S MAIDEN NAME

Bettie Spicers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

M's Cora Bridges 536 Moore St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Occlusion

?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Coronary Heart Disease

## II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/20/49, to 3/25/50, that I last saw the deceased alive on 3/25/50, and that death occurred at 9:08 PM from the causes and on the date stated above.

23A. SIGNATURE

J. W. Garner

M. D.

23B. ADDRESS

23 C. DATE SIGNED

3/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-31-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Tarboro, North Carolina

DATE RECEIVED BY LOCAL REGISTRAR

MAR 29 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

(Mrs) Frances A. Hemsley

ADDRESS

578 W. Biddle St.







5-636  
50 2922  
SHORTER  
50 2922  
Registered No.  
BIRTH NO.  
1. NAME OF DECEASED  
(Type or Print)  
2. DATE OF DEATH  
3. PLACE OF DEATH:  
a. Baltimore City, Maryland  
b. FULL NAME OF HOSPITAL OR INSTITUTION  
c. Length of stay in Baltimore  
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE  
b. COUNTY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
d. STREET ADDRESS (If rural, give location)  
5. DATE OF BIRTH  
6. AGE (In years last birthday)  
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
8. BIRTHPLACE (State or foreign country)  
9. CITIZEN OF WHAT COUNTRY?  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
11. KIND OF BUSINESS OR INDUSTRY  
12. FATHER'S NAME  
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
14. SOCIAL SECURITY NO.  
15. INFORMANT  
16. ADDRESS  
17. CAUSE OF DEATH  
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
19. ANTECEDENT CAUSES  
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
21. DATE OF OPERATION  
22. MAJOR FINDINGS OF OPERATION  
23. AUTOPSY?  
24. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.  
25. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
27. TIME (Month) (Day) (Year) (Hour) OF INJURY  
28. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK  
29. HOW DID INJURY OCCUR?  
30. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.  
31. SIGNATURE  
32. CHIEF MEDICAL EXAMINER, ASSISTANT MEDICAL EXAMINER, MEDICAL INVESTIGATOR  
33. DATE SIGNED  
34. BURIAL, CREMATION, DATE, NAME OF CEMETERY OR CREMATORY, LOCATION (City, town, or county) (State)  
35. DATE RECEIVED BY LOCAL REGISTRAR  
36. REGISTRAR'S SIGNATURE  
37. FUNERAL DIRECTOR  
38. ADDRESS

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

d. STREET ADDRESS (If rural, give location)

5. DATE OF BIRTH

6. AGE (In years last birthday)

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. BIRTHPLACE (State or foreign country)

9. CITIZEN OF WHAT COUNTRY?

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. FATHER'S NAME

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

14. SOCIAL SECURITY NO.

15. INFORMANT

16. ADDRESS

Bernard Shorter 1105 E. Pratt St

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Atherosclerotic C.V. Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Obesity

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER, ASSISTANT MEDICAL EXAMINER, MEDICAL INVESTIGATOR

23C. DATE SIGNED

24A. BURIAL, CREMATION, DATE

24B. NAME OF CEMETERY OR CREMATORY

24C. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2923  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Miller

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

14-02

D. STREET ADDRESS (If rural, give location)

1519 McCullough St.

c. Length of stay in Baltimore

55 yrs

SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 6, 1875

9. AGE (In years  
last birthday)

74

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Gardner

10B. KIND OF BUSINESS OR  
INDUSTRY

Private family

11. BIRTHPLACE (State or foreign country)

Chatanooga, Tenn.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. James Press 2548 Madison Ave.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inc. thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. B. Fisher

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

March 27, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/30/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Holland Funeral Home  
1631 Druid Hill Ave.

ADDRESS







**J. BROWER GARDNER**  
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

50 2924  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*J. Brower Gardner*

2. DATE  
OF  
DEATH

*3/28/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*Memey Hospital*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH

*March 6, 1877*

9. AGE (In years  
last birthday)

*73*

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Chief Bailiff*

10B. KIND OF BUSINESS OR  
INDUSTRY  
*Supreme Bench  
Balto. City*

11. BIRTHPLACE (State or foreign country)

*Pa.*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Joseph Gardner*

14. MOTHER'S MAIDEN NAME

*Anne Cannox*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL  
SECURITY NO.

*no*

17. INFORMANT

*Mrs. J. Brower Gardner 3415 Mondawmin*

ADDRESS

18. *4 yr. 1*

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Anteroseptal C. V. disease*  
DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*J. J. Pulawski*

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED  
*3/28/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/31/50*

24C. NAME OF CEMETERY OR CREMATORY

*Lorraine Cem.*

24D. LOCATION (City, town, or county)

*Woodlawn, Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston, M. J. Tickner & Sons*

25. FUNERAL DIRECTOR

*M. J. Tickner & Sons*

ADDRESS

*Balto., Md.*



CERTIFICATE OF DEATH

Record No. \_\_\_\_\_

Full Name of Deceased \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Place of Birth \_\_\_\_\_

Usual Residence \_\_\_\_\_

Occupation \_\_\_\_\_

Married \_\_\_\_\_

Cause of Death \_\_\_\_\_

Immediate Cause \_\_\_\_\_

Underlying Cause \_\_\_\_\_

Contributing Cause \_\_\_\_\_

Duration of Illness \_\_\_\_\_

Time of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Medical Examiner \_\_\_\_\_

Signature of \_\_\_\_\_



50 2925

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2925

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BESSIE SOPER OMAN

2. DATE  
OF  
DEATH

3/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)Maryland Baltimore  
Relay 5200

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1010 Francis Avenue

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11/25/1888

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Soper

14. MOTHER'S MAIDEN NAME

Cora W. Jump

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

D. T. Oman

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

INTERVAL BETWEEN  
ONSET AND DEATH

approx 4 hrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/27, 1950, to 3/27, 1950, that I last saw the  
deceased alive on 3/27, 1950, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert J. Devickas

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

3/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Grace Cem.,

24D. LOCATION (City, town, or county) (State)

Elkridge, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Livingston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

W. J. TICKNER &amp; SONS

Balto., Md.



RECEIVED

12

QUC

12

12



50 2926

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2926  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MABEL TRIBBY

2. DATE  
OF  
DEATH

March 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION 708 N. Fulton Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-04

D. STREET ADDRESS (If rural, give location)  
708 N. Fulton Ave.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widow

8. DATE OF BIRTH

April 5, 1883

9. AGE (In years,  
last birthday) 66

10. Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
housewife

10B. KIND OF BUSINESS OR INDUSTRY  
own home

11. BIRTHPLACE (State or foreign country)  
Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frey

14. MOTHER'S MAIDEN NAME  
Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
no

17. INFORMANT ADDRESS  
Miss Virginia Boryner 708 N. Fulton Av

18. 4/20/11

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

immediate death

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardiovascular Disease 20 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Nephrosclerosis

20 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 1948 to March 28 1950, that I last saw the deceased alive on 27 Mar. 1950, and that death occurred at 8:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. B. Bayless

23B. ADDRESS

1600 Wilkins Ave

23C. DATE SIGNED

29 Mar 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Removal

24B. DATE

3/30/50

24C. NAME OF CEMETERY OR CREMATORY

Union Cem.

24D. LOCATION (City, town, or county)

Lorettsville, Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Tickner, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. TICKNER & SONS

Balto., Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



1950

U.S.A.

100%

BOND

COMBRESS

VALLEY

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2-432  
50 2927

Ja 6100

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2927

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) *Mr. Michael Goldstein* 2. DATE OF DEATH *3-28-50*

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE *Md* B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION *Levin dale* C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Baltimore 14-01*

70 D. STREET ADDRESS (If rural, give location) *Levin dale 1942*

Length of stay in Baltimore *60* Yrs. *60* Mos. *60* Days

5. SEX *Male* 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widowed* 8. DATE OF BIRTH *85* 9. AGE (In years, If Under 1 Year Months: Days Hours: Min. *65*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Retired* 10B. KIND OF BUSINESS OR INDUSTRY *Redder* 11. BIRTHPLACE (State or foreign country) *Russia* 12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13. FATHER'S NAME *Louis* 14. MOTHER'S MAIDEN NAME *Rose*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT *Joseph Fisher* ADDRESS *3109 Sequoia Ave*

18. *297 X I* CAUSE OF DEATH *Agranulocytosis* INTERVAL BETWEEN ONSET AND DEATH *4 months*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) *Etiology unknown*

ANTECEDENT CAUSES (B) *Paget's disease*

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. \_\_\_\_\_

19A. DATE OF OPERATION \_\_\_\_\_ 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED \_\_\_\_\_ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from *January 16, 1948*, to *March 28, 1950*, that I last saw the deceased alive on *3-28, 1950*, and that death occurred at *4:35 p. m.*, from the causes and on the date stated above.

23A. SIGNATURE *Jerome J. Blumberg* M. D. 23B. ADDRESS *Levin dale Home* 23C. DATE SIGNED *3-28-50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *3-29-50* 24C. NAME OF CEMETERY OR CREMATORY *Mishkoun Israel* 24D. LOCATION (City, town, or county) (State) *Balto Md*

DATE RECEIVED BY LOCAL REGISTRAR *29-3-50* REGISTRAR'S SIGNATURE *William H. ...* 25. FUNERAL DIRECTOR *Jack Levine* ADDRESS *2100 Cutaw Pl*

VS 150

155

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



1942 Sudan 22

VALLEY  
CONCRETE  
CONCRETE  
CONCRETE







DEPARTMENT OF HEALTH

1914

1914

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1914

1914



50 2929

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2929

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ADA G. SCOTT

2. DATE  
OF  
DEATH

3/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2015 McCulloh St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

14-03

D. STREET ADDRESS (If rural, give location)

2015 McCulloh St

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5/16/1895

9. AGE (In years,  
last birthday)

54

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR  
INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Gloucester, Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. Tazwell

14. MOTHER'S MAIDEN NAME

MaryEllen Rowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Cynthia Thompson(S) 2015 McCulloh St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic Cardiovascular  
renal disease

(C) DUE TO

Coronary occlusion

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from January 1, 1950 to March 24, 1950 that I last saw the deceased alive March 22, 1950 and that death occurred at 8:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

D. Shorofsky M.D.

23B. ADDRESS

601 N. Monroe St.

23C. DATE SIGNED

3/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/30/50

24C. NAME OF CEMETERY OR CREMATORY

Shiloh Baptist Cem.

24D. LOCATION (City, town, or county)

Gloucester, Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Emington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles G. Cooper-512 N. Carrollton

Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



100-100000-100000

100-100000-100000  
100-100000-100000  
100-100000-100000

100-100000-100000  
100-100000-100000  
100-100000-100000

100-100000-100000



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

To Be Approved By Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 2930

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Etta Julia Clayton

2. DATE  
OF  
DEATH

March 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 18,

D. STREET ADDRESS (If rural, give location)

718 E. 30th. St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

Care Worker

13. FATHER'S NAME

Erans J. Dickerman

8. DATE OF BIRTH

Nov. 18, 1886

9. AGE (In years last birthday)

63

11 Under 1 Year Months: Days

12 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Harford, Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Wm. J. Wm. J.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Joseph E. Van Dusen 2511 Keith

18. E903.5

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Single comminuted intertrochanteric fracture - right femur

7 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fall

DUE TO

CERTIFICATION APPROVED BY

Dr. J. R. Davis

per: J. R. Fisher M.D.

CHIEF OR ASST. MED. CAL EXAMINER

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Acute and chronic alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Crossing Hoffman St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Feb. 4, 1950

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped and fell to street

22. I hereby certify that I attended the deceased from February 5, 1950, to March 28, 1950, that I last saw the deceased alive on 3-27, 1950, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. Joseph Kray

M. D.

23B. ADDRESS

1100 N. Caroline St.

23C. DATE SIGNED

3/28/50

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 29 1950

REGISTRAR'S SIGNATURE

Wm. J. Wm. J.

25. FUNERAL DIRECTOR

John W. Conklin

ADDRESS

924 E. Eager St.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

OTHER



correct age is especially important. Physicians write the causes of death clearly and legibly.

200

50 2931

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2931  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*William H. Keys*

2. DATE  
OF  
DEATH

*3/24/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*806 Edmondson ave*

C. Length of stay in Baltimore

5. SEX

*Male*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Laborer*

10B. KIND OF BUSINESS OR INDUSTRY

*Fastory*

13. FATHER'S NAME

*William H. Keys*

15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Maryland*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 17-03*

D. STREET ADDRESS (If rural, give location)

*806 Edmondson ave*

8. DATE OF BIRTH

*8/10/1881*

9. AGE (In years last birthday)

*68*

11. BIRTHPLACE (State or foreign country)

*Va*

12. CITIZEN OF WHAT COUNTRY?

*U S A*

14. MOTHER'S MAIDEN NAME

*Georgia Bailey*

17. INFORMANT

ADDRESS

*Mrs Bertha Johnson 806 Edmondson*

18. *420.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Anterior lentec. Disease  
Heart*

INTERVAL BETWEEN ONSET AND DEATH

*?*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*Coronary Failure*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *3/22/50*, to *3/24/50*, that I last saw the deceased alive on *3/23/50*, and that death occurred at *9:20 AM* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (Style)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

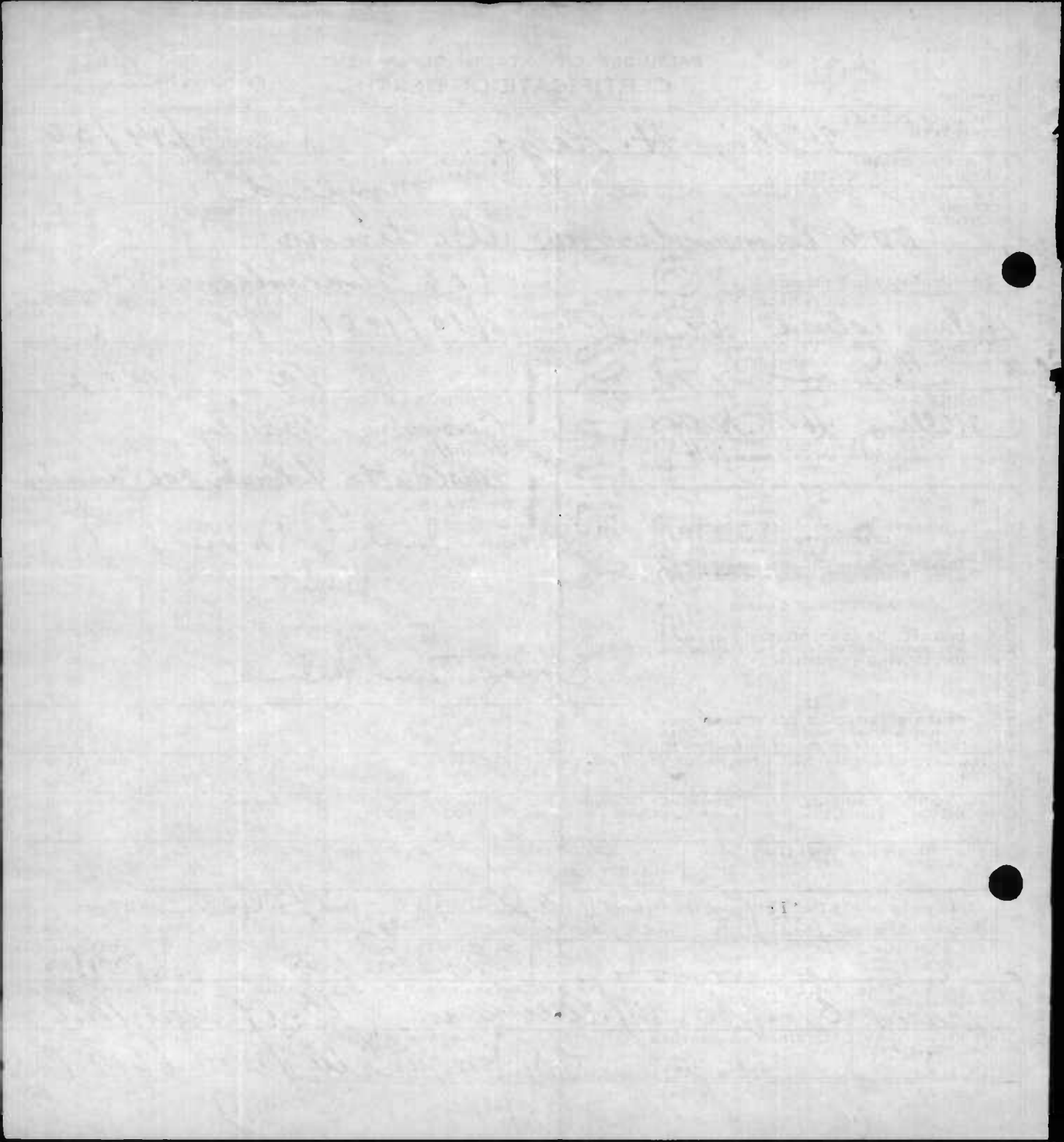
25. FUNERAL DIRECTOR

ADDRESS

*3/29/50*

*Timothy W. Williams, Jr. Joseph A. Lively 661 W. Barge*







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*JOHN Wm. WICKARD*

2. DATE  
OF  
DEATH

*3/29/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Lindis-Madison*

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

*Md*

B. COUNTY

*9-02*

B. FULL NAME OF HOSPITAL OR INSTITUTION

*Md. Gen'l Hosp.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 18*

D. STREET ADDRESS (If rural, give location)

*1505 Shadyside Rd*

Length of stay in Baltimore

*Life 6 yrs*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

*Mar 12, 1862*

9. AGE (In years last birthday)

*88*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Editor*

10B. KIND OF BUSINESS OR INDUSTRY

*Newspaper*

11. BIRTHPLACE (State or foreign country)

*Md (Cumberland)*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*Jacob Wickard*

14. MOTHER'S MAIDEN NAME

*Wm. Carlton*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give War or dates of service)

*No*

*NONE*

16. SOCIAL SECURITY NO.

*Patent*

ADDRESS

18. *E903.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Circulatory collapse*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*4 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Hypostatic pneumonia*

DUE TO

*7 days*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

*Fracture left hip*

*13 days*

CERTIFICATION APPROVED BY

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

*H. J. Mc Clafferty M. D.*  
CHIEF OR ASST. MEDICAL EXAMINER

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

*Accident*

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

*Home*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

*1505 Shadyside Rd*

*9/2*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

*Mar 14, 50 5:30 A. m.*

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

*Slipped on rug*

22. I hereby certify that I attended the deceased from *3/14*, 19*50*, to *3/29*, 19*50*, that I last saw the deceased alive on *3/28*, 19*50*, and that death occurred at *2:30* A. m., from the causes and on the date stated above.

23A. SIGNATURE

*Ernest A. Curran M. D.*

23B. ADDRESS

*Maryland Gen'l Hosp*

23C. DATE SIGNED

*3/29/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*3/30/50*

24C. NAME OF CEMETERY OR CREMATORY

*Rosehill*

24D. LOCATION (City, town, or county)

*Cumberland*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Stouffer-Morris & Co. Balto.*

ADDRESS

VS 150

*N-820.1*

*186a*

MEDICAL CERTIFICATION







3-242  
50 2933BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2933  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ALBERT EDWARD SCHULZ

2. DATE  
OF  
DEATH

March 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1206 N. Milton Ave.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTIONYrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1206 N. Milton Avenue

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Glenn L. Martin Co.

13. FATHER'S NAME

Albert Schulz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.  
214-22-6110

8. DATE OF BIRTH

Jan 15, 1886

9. AGE (In years last birthday)

64

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

14. MOTHER'S MAIDEN NAME

Mary Heintzman

17. INFORMANT

ADDRESS

Clara E. Phillips, dght - 407 Edsdale Rd.

18. 181X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cachexia and Metastasis

108 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Carcinoma of Urinary Bladder 3 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1949 to March 26, 1950, that I last saw the deceased alive on March 26, 1950, and that death occurred at 3:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Albert Eisenberg

M. D.

23B. ADDRESS

2025 E North Ave

23C. DATE SIGNED

March 27, 1950

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Mar. 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

4300 Old Frederick Road, Balto.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAR 29 1950

VS 150

REGISTRAR'S SIGNATURE

Huntington

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
2601 43-5 E. Madison St.

ADDRESS

correct age is especially important. Physicians please write the causes of death clearly and legibly.

988 38

52 B







correct age is especially important. Physicians write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FRANCIS JOSEPH CASSIDY, Jr.

2. DATE OF DEATH  
March 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2452 E. Eager St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore life

5. SEX  
male

6. COLOR OR RACE  
white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 7-02

D. STREET ADDRESS (If rural, give location)  
2452 E. Eager St.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
retired

10B. KIND OF BUSINESS OR INDUSTRY  
B.C.&A. Steamboat Co.

11. BIRTHPLACE (State or foreign country)  
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

Francis Joseph Cassidy, Sr.

14. MOTHER'S MAIDEN NAME

Sarah Eagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
no

17. INFORMANT

ADDRESS

Margaret Cassidy, wife, 2452 E. Eager St.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertension of the heart

DUE TO

(B) Vascular disease

DUE TO

(C) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

6 hrs

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2 of 1-1949, to March 28, 1950, that I last saw the deceased alive on 3-27-50, and that death occurred at 1 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR  
MAR 29 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.  
2601 E. E. Madison St.



DECLARATION OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH

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PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH



# CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 2935

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Patrick Thomas Mersman*

2. DATE  
OF  
DEATH

*3/27/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*700 N. Luzerne Ave*

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*700 N. Luzerne Ave*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*widowed*

8. DATE OF BIRTH

*March 17, 1861*

9. AGE (In years last birthday)

*87 89*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*retired*

10B. KIND OF BUSINESS OR INDUSTRY

*Balto. City.*

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*unknown*

14. MOTHER'S MAIDEN NAME

*unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL SECURITY NO.

*no*

17. INFORMANT

ADDRESS

*Jos. F. Mersman - son - 700 N. Luzerne Ave.*

18. *4221*

### CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Ante-mortem disease*  
DUE TO

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *.....*  
DUE TO

II

(C) *.....*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*P. P. Sub...*

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ M.D. MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

*3/27/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 30, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*New Cathedral Cemetery*

24D. LOCATION (City, town, or county) (State)

*4300 Old Fred'k. Rd. Balto. Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington, Delaware, Md.*

25. FUNERAL DIRECTOR

*Schimunek Funeral Home, Inc.*

ADDRESS

*2601-9-5 E. Madison St.*



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

NEW YORK, N.Y.

DECEMBER 1, 1911

REPORT

REPORT

OF THE DEPARTMENT OF HEALTH

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MS--136846

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2936

BIRTH NO. 620 50 2936 49-14662

1. NAME OF DECEASED (Type or Print) Robert Joseph Marks			2. DATE OF DEATH Mar. 27, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-07		
D. STREET ADDRESS (If rural, give location) 4101 E. Lombard St. Zone 24			Yrs. Mos. Days		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 8, 1949		9. AGE (In years last birthday) 8 19
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Marks			14. MOTHER'S MAIDEN NAME Florence Bennett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records* Balto. City Hospitals 4940 Eastern Ave.		

18. 330 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Sub-arachnoid hemorrhage, left spontaneous		INTERVAL BETWEEN ONSET AND DEATH over
CAUSE OF DEATH (A) DUE TO		
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-26-1950 to 3-27-1950, that I last saw the deceased alive on 3-27-1950 and that death occurred at 4:30 P.M., from the causes and on the date stated above.					
23A. SIGNATURE R. J. Rogers		23B. ADDRESS 4940 Eastern Ave.		23C. DATE SIGNED 3-28-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar 29/50		24C. NAME OF CEMETERY OR CREMATORY Mt Carmel Cem		24D. LOCATION (City, town, or county) (State) Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR MAR 29 1950		REGISTRAR'S SIGNATURE Huntington Williams, Jr.		25. FUNERAL DIRECTOR R. J. Rogers		ADDRESS 208 Adams St	



Letter in document file 50-2936 - 5/4/50.







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AB--97971

50

2938

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50

2938

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Silas Evans

2. DATE  
OF  
DEATH

March 15-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Homeless (Baltimore City Hospitals)

5. SEX

M

6. COLOR OR RACE

N

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept-15-1893

9. AGE (In years  
last birthday)

56

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

OPD JOB

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY

13. FATHER'S NAME

London

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Baltimore City Hospitals  
Records: 4940 Eastern Ave.

ADDRESS

18. 491X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 12-19-1945 to 3-15-1950, that I last saw the  
deceased alive on 3-15-1950, and that death occurred at 10.40 AM, from the causes and on the date stated above.

23A. SIGNATURE

J. S. Brown

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

3-28-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

March 28, 1950

Mt. Auburn

Westport, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 29 1950

Huntington Williams, Jr.

Charles J. Alexander, 1200 McCulloch St.

VS 150

98899

107

correct age is especially important. Physicians - please write the cause of death.



1-1-1

(1-1-1)

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1-1-1

1-1-1

1-1-1



D-626

JL-129134

BALTIMORE CITY HEALTH DEPARTMENT

50 2939  
Registered No.

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nancy Drager

2. DATE  
OF  
DEATH

3-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

346 Elrino St- 24

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 21, 1947

9. AGE (In years,  
last birthday)

3

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Drager

14. MOTHER'S MAIDEN NAME

Eleanor Piker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

B. C. H. Records.

ADDRESS

18. D I D X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Tuberculous Meningitis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-21-47, 19, to Mar. 27, 19 50 that I last saw the  
deceased alive on Mar. 27, 19 50, and that death occurred at 11.15 AM from the causes and on the date stated above.

23A. SIGNATURE

J. H. Rogers M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

3-27-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-1-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto - Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

J. H. Rogers  
403 S. Wolfe St.

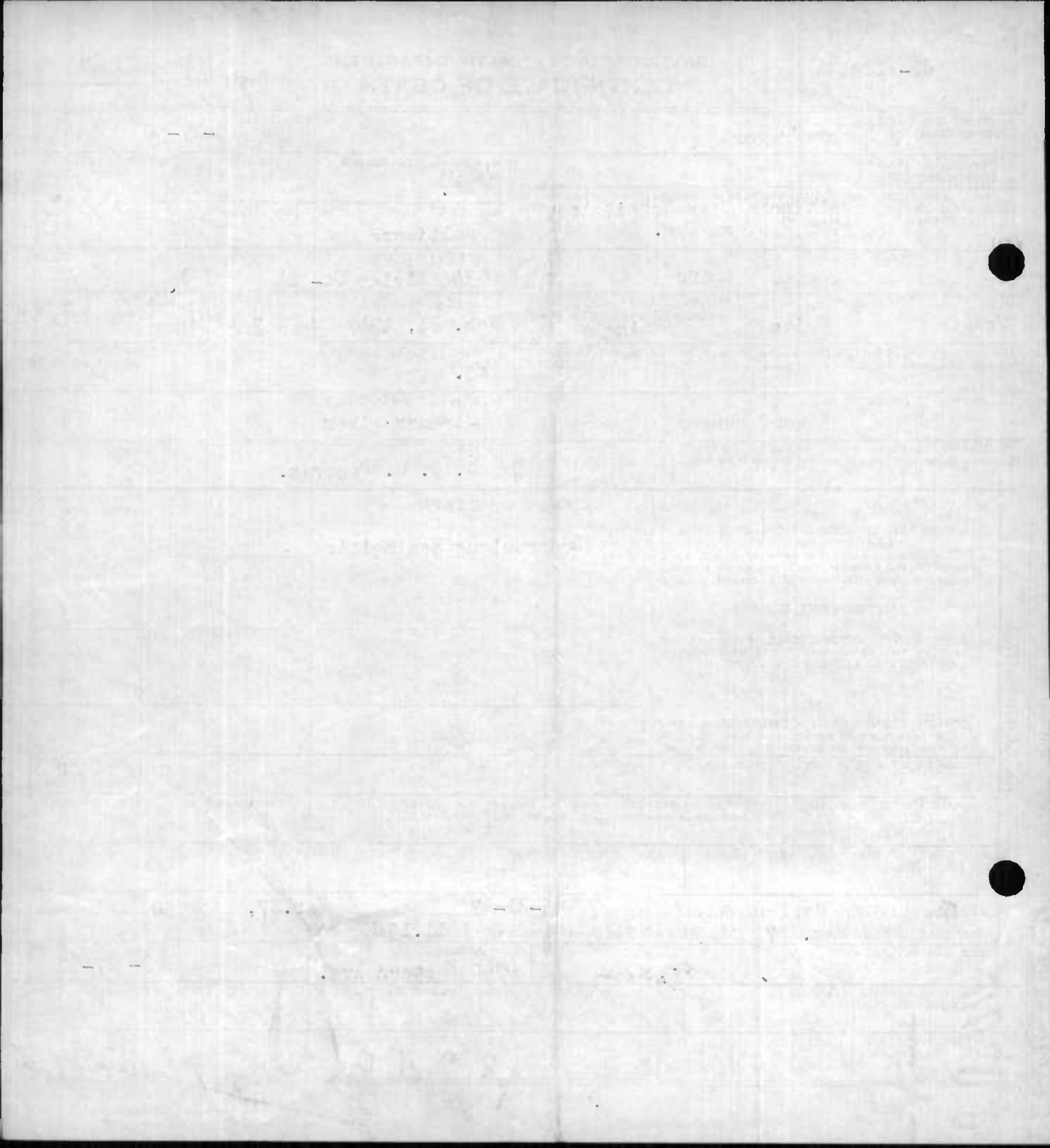
VS 150

MAR 29 1950

14

MEDICAL CERTIFICATION  
correct age is especially important. Physicians: please write the causes of death clearly and briefly.







8-452  
50 2940BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2940  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Ida Collins</i>		2. DATE OF DEATH <i>Mar. 27, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2514 Madison Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>13-03</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2514 Madison Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Jan. 3, 1878</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	9. AGE (In years last birthday) <i>72</i>
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Finney</i>		14. MOTHER'S MAIDEN NAME <i>Laura Young</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William Custis</i>		ADDRESS <i>805 N. Fremont Ave.</i>	

18. <i>442x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>remiss cancer</i> DUE TO (B) <i>My peritumori Cardiac</i> DUE TO (C) <i>vascular renal disease</i> INTERVAL BETWEEN ONSET AND DEATH	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
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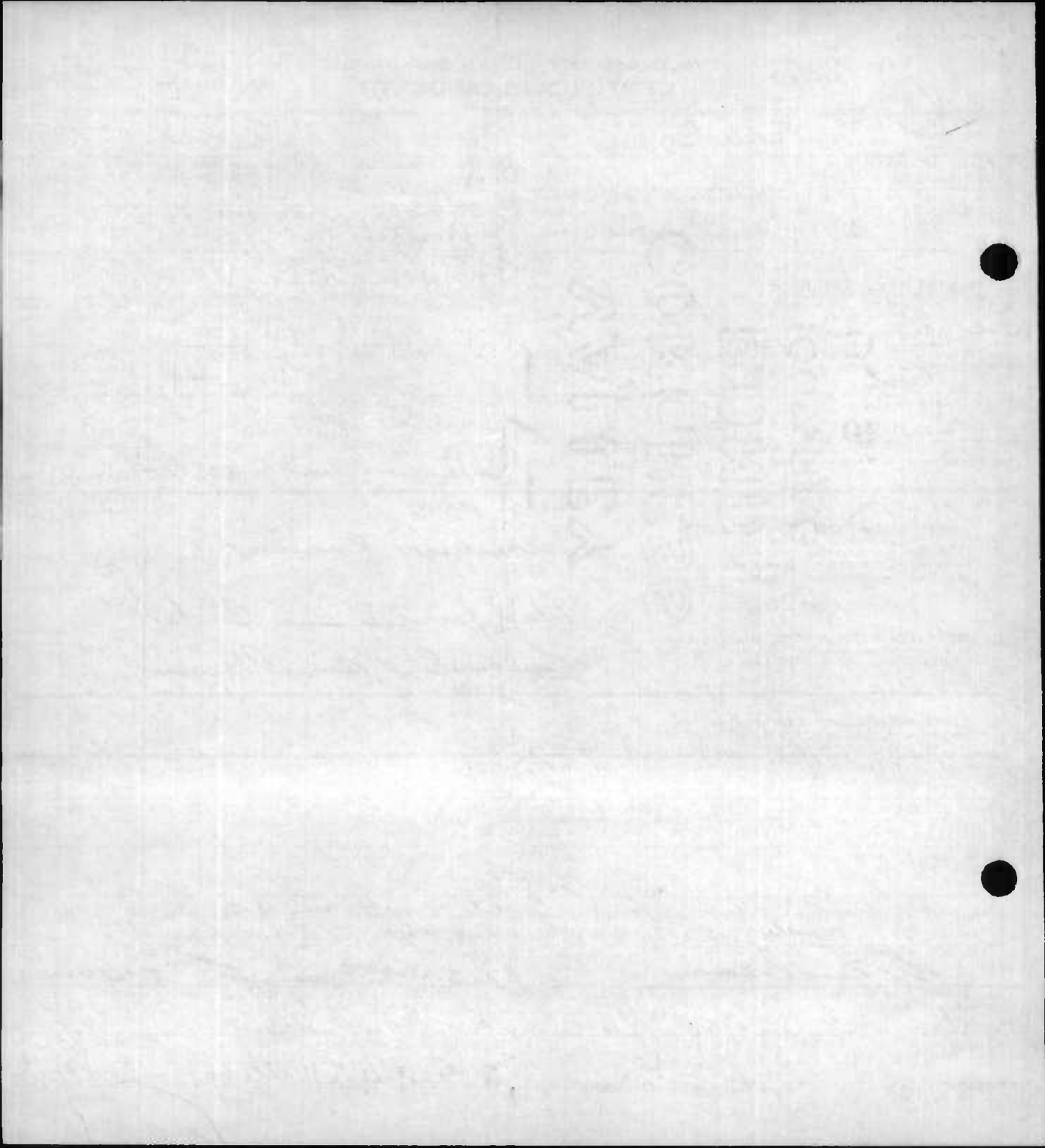
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Jan. 1, 1950</i> to <i>March 27, 1950</i> , that I last saw the deceased alive on <i>March 27, 1950</i> , and that death occurred at <i>8:45 p.m.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>William Custis</i>		23B. ADDRESS M. D. <i>805 N. Fremont</i>		23C. DATE SIGNED <i>5-29-50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-30-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem. Balto.</i>	24D. LOCATION (City, town, or county) (State) <i>Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 29 1950</i>	REGISTRAR'S SIGNATURE <i>William Custis</i>	25. FUNERAL DIRECTOR <i>Thos. H. Williams</i> ADDRESS <i>322 N. Schroeder St.</i>	

52006

131a







6-620

50 2941

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2941

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES AUGUSTUS ERICH</b>		2. DATE OF DEATH <b>Mar. 27, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2025 E. Oliver St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>8-07</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2025 E. Oliver St.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Nov. 27, 1882</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Western Elec. Co.</b>	9. AGE (In years last birthday) <b>67</b>
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles A. Erich</b>		14. MOTHER'S MAIDEN NAME <b>Rosanna Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-05-0793</b>	
17. INFORMANT <b>Mrs. J. W. Diggs</b>		ADDRESS <b>615 Park Ave.</b>	

18. **002X**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary embolism**  
DUE TO**sudden**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Brachiectasis**  
DUE TO**5 yrs.**

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **Pulmonary Tuberculosis**  
**Generalized arteriosclerosis****?**19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12/28**, 1946 to **3/27**, 1950 that I last saw the deceased alive on **3/22**, 1950, and that death occurred at **6:15 P. M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

**Burial****3/29/50****Lorraine Park Cem.****Woodlawn, Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**MAR 29 1950****Huntington Williams, M.D.****M. O. TIGHER & SONS****Balto., Md.**

VS 150

34835

1312

correct age is especially important. Physicians, please write the cause of death.

MEDICAL CERTIFICATION



DECLARATION OF DEATH

STATE OF NEW YORK

DATE OF DEATH

NAME OF DECEASED

RESIDENCE

AGE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Declarant

Signature of Physician

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

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DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH



N-425

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2942

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

La Verne NELSON

2. DATE  
OF  
DEATH

26 March '50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

Balt. City

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

16-07

D. STREET ADDRESS (If rural, give location)

1107 Mosher

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

B

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

12-13-1945

9. AGE (In years  
last birthday)

4

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

EDWARD NELSON

14. MOTHER'S MAIDEN NAME

FREDI JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

FREDI A. JOHNSON MOSHER ST.

18. 351X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Palsy

4 yrs

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 26 Mar., 1950, to 26 Mar., 1950, that I last saw the  
deceased alive on 25 Mar., 1950, and that death occurred at 9:34 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Raymond B. Benjamin

M. D.

23B. ADDRESS

University - Hosp.

23C. DATE SIGNED

3/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

3-31-50

MT. AUBURN

BALTIMORE, MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

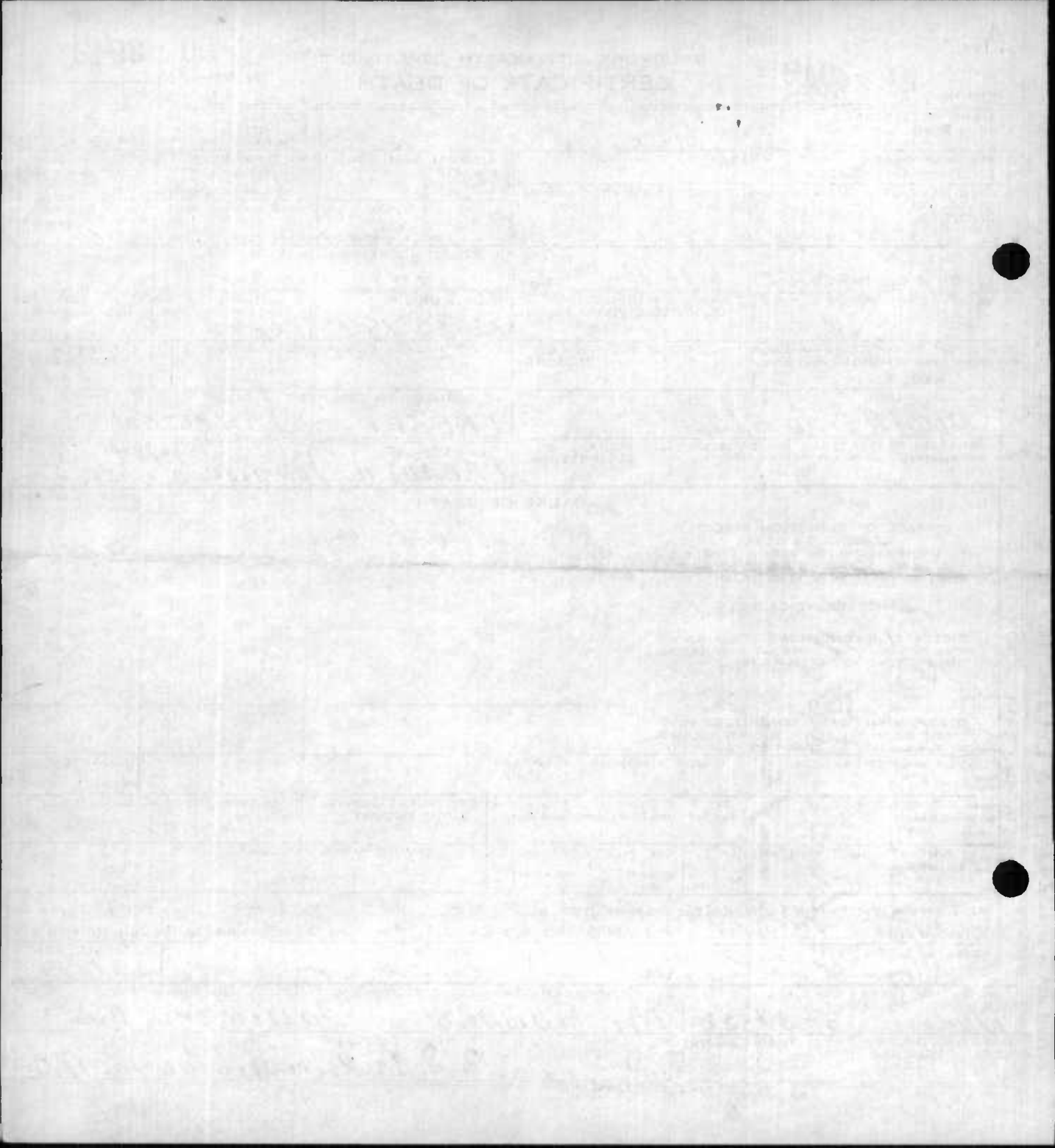
ADDRESS

MAR 29 1950

W. A. JACKSON - 916 PENNA. AVE.

W. A. JACKSON - 916 PENNA. AVE.







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

BIRTH NO. **50 2943**

**50 2943**  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Mrs. Annie E. Belt</b>			2. DATE OF DEATH <b>March 27, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1024 Union Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 13-07</b>		
D. STREET ADDRESS (If rural, give location) <b>1024 Union Avenue</b>			E. Length of stay in Baltimore <b>Life</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>January 30, 1876</b>		9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>Aquilla Wheeler</b>		
14. MOTHER'S MAIDEN NAME <b>Elizabeth Porter</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>---</b>			17. INFORMANT ADDRESS <b>Charles A. Belt 1024 Union Avenue</b>		

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Myocarditis</b> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Anterior Arterio Sclerotic Cardiovascular Renal Disease</b> (B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Feb. 15</b> , 1950, to <b>Mar. 27</b> , 1950, that I last saw the deceased alive on <b>Mar. 27</b> , 1950, and that death occurred at <b>9:05 P. m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <i>James E. Brode</i>	23B. ADDRESS <b>1331 North Ave.</b>	23C. DATE SIGNED <b>3-27-50</b>		

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>March 30, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 29 1950</b>	REGISTRAR'S SIGNATURE <i>Washington Hollingsworth</i>	25. FUNERAL DIRECTOR ADDRESS <b>Burgee Funeral Home 3631 Falls Road</b>	



Mr. Hoffe  
1331 E. North A



C-516  
50 2944

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2944  
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland  
(b) Street address <sup>4700-</sup>4702 Harford Road  
(c) Hospital or institution: Harford Nursing Home  
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks  
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County Baltimore  
(c) City or town Baltimore 20-04  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. 2548 W. Pratt St. -23  
(If rural give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3 (a) FULL NAME

Sophia L. Chambers

3 (b) If veteran, name war

-no-

3 (c) Social Security Account

No. —

4. Sex

f

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife Thomas N. Chambers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-14-70

8. AGE:

Years

Months

Days

If less than one day

79

10

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation housewife - none at present

11. Industry or business

FATHER

12. Name Henry. Woodall

13. Birthplace England

MOTHER

14. Maiden Name Margaret Ann Richter

15 Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Natalie Emory

(b) Address 2548 W. Pratt St. -23

17 (a) Burial (b) Date thereof 3-30-50

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Road, Balto. Md

18 (a) Funeral director Geo. L. Bever Jr.

(b) Address 1512 Hollins St. -23

19 (a) (b) (Date received by Registrar)

MAR 29 1950

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-50 19 —, at — M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25-50 19 — to 3-26-50 19 —, and that I last saw her alive on 3-27-50 19 —.

Immediate cause of death

cardio-vascular disease

Duration

sev. yrs.

Due to old age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 0

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide  
(b) Date of occurrence — at — M  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?  
(Specify type of place)  
(e) Means of injury

23. Signature

Med. Auto Bldg Address — Date signed 3/27/50

PHYSICIAN

Underline the cause to which death should be charged statistically.

93D



# INSTRUCTIONS FOR MEDICAL CERTIFICATION

---

## WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

## DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

## DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

## DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



P-620  
50 2945BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2945  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Warren Parks

2. DATE  
OF  
DEATH

3/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

941 S Sharp St

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

E

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

8/11/1893

9. AGE, in years  
last birthday

56

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Grayhound Bus Station

11. BIRTHPLACE (State or foreign country)

West Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Moses Parks

14. MOTHER'S MAIDEN NAME

Susan Nunnery

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Susie Laws - 941 Sharp St

18. 002 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Pulmonary Tuberculosis

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/21/50, 19\_\_, to 3/27/50, 19\_\_, that I last saw the  
deceased alive on 3/27, 1950, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 29 1950

75049

1312

What life is especially important. Physicians: please write the causes of death clearly and legibly.







B-452

CERTIFICATE CORRECTED 4-5-60

BALTIMORE CITY HEALTH DEPARTMENT

50 2946

BIRTH NO. 50 2946

## CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Mary Blanchard

2. DATE OF DEATH MAR 29 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Md B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 12-08D. STREET ADDRESS (If rural, give location)  
260 W. 31st St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 86

9. AGE (In years last birthday) 64 65

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

London, England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

David J. Hockney

14. MOTHER'S MAIDEN NAME

Mary J. Hardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 592X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

1 yr.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Chr. glomerulonephritis

(C) c anuria

5 d.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-21-1950 to 3-29-1950, that I last saw the deceased alive on 3-24-1950, and that death occurred at 1400 am., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 29 1950

131B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. GOVERNMENT PRINTING OFFICE

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of burial place		17. Signature of interment		18. Signature of cremation	
19. Signature of crematorium		20. Signature of cremation		21. Signature of cremation	
22. Signature of cremation		23. Signature of cremation		24. Signature of cremation	
25. Signature of cremation		26. Signature of cremation		27. Signature of cremation	
28. Signature of cremation		29. Signature of cremation		30. Signature of cremation	
31. Signature of cremation		32. Signature of cremation		33. Signature of cremation	
34. Signature of cremation		35. Signature of cremation		36. Signature of cremation	
37. Signature of cremation		38. Signature of cremation		39. Signature of cremation	
40. Signature of cremation		41. Signature of cremation		42. Signature of cremation	
43. Signature of cremation		44. Signature of cremation		45. Signature of cremation	
46. Signature of cremation		47. Signature of cremation		48. Signature of cremation	
49. Signature of cremation		50. Signature of cremation		51. Signature of cremation	
52. Signature of cremation		53. Signature of cremation		54. Signature of cremation	
55. Signature of cremation		56. Signature of cremation		57. Signature of cremation	
58. Signature of cremation		59. Signature of cremation		60. Signature of cremation	
61. Signature of cremation		62. Signature of cremation		63. Signature of cremation	
64. Signature of cremation		65. Signature of cremation		66. Signature of cremation	
67. Signature of cremation		68. Signature of cremation		69. Signature of cremation	
70. Signature of cremation		71. Signature of cremation		72. Signature of cremation	
73. Signature of cremation		74. Signature of cremation		75. Signature of cremation	
76. Signature of cremation		77. Signature of cremation		78. Signature of cremation	
79. Signature of cremation		80. Signature of cremation		81. Signature of cremation	
82. Signature of cremation		83. Signature of cremation		84. Signature of cremation	
85. Signature of cremation		86. Signature of cremation		87. Signature of cremation	
88. Signature of cremation		89. Signature of cremation		90. Signature of cremation	
91. Signature of cremation		92. Signature of cremation		93. Signature of cremation	
94. Signature of cremation		95. Signature of cremation		96. Signature of cremation	
97. Signature of cremation		98. Signature of cremation		99. Signature of cremation	
100. Signature of cremation		101. Signature of cremation		102. Signature of cremation	



L-535

50 2947

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2947  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth D. Lindner

2. DATE  
OF  
DEATH

March 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

3521 S. Hanover St.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3521 S. Hanover St.

C. Length of stay in Baltimore

8

Yrs.  
Mos.  
Days

5. SEX

f-

6. COLOR OR RACE

wh

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 16, 1882

9. AGE (in years,  
last birthday)

68

10. Under 1 Year  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife; clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Boston Shoe Rep.

13. FATHER'S NAME

William Lindner

11. BIRTHPLACE (State or foreign country)

Kansas, Mo.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

215 22 52 62

17. INFORMANT William Thomas Lindner

ADDRESS

husband

Same

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

generalized carcinoma

5 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

cancer of the uterus

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELAT-  
E TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

Sept. 1949

19B. MAJOR FINDINGS OF OPERATION

Biopsy: cancer of cervix of uterus (inoperable)

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1950, to March 27, 1950, that I last saw the  
deceased alive on March 27, 1950, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Newman

23B. ADDRESS

M. O.

936 Patapsco Ave.

23C. DATE SIGNED

March 28, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

J. J. Lucko 5808 Maryland Rd. - 14

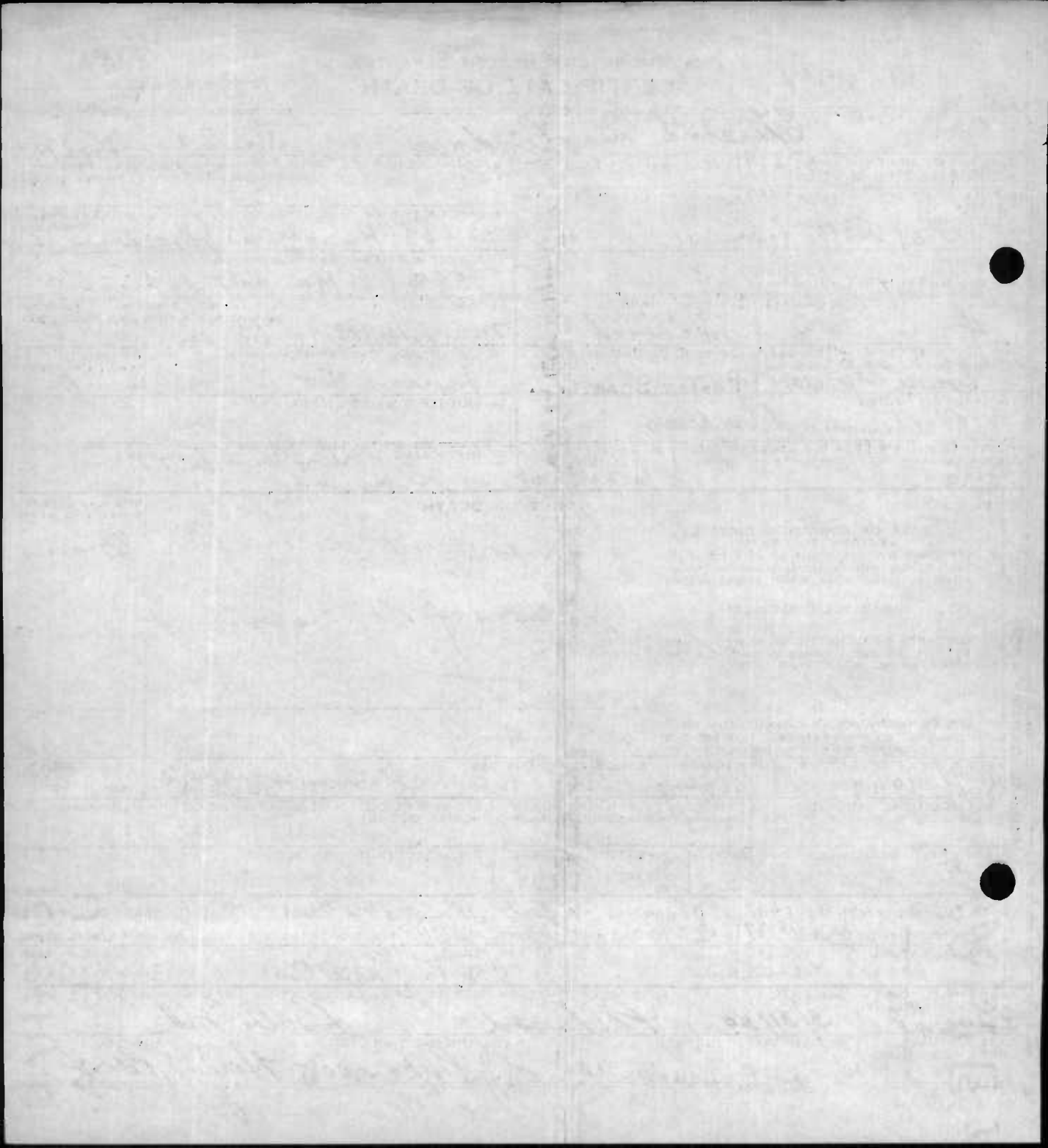
ADDRESS

MAR 29 1950

48 B

MEDICAL CERTIFICATION







H-200  
50 2948BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2948

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Selma E. Hess

2. DATE  
OF  
DEATH

Mar. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Greenspring Manor Apts

c. Length of stay in Baltimore 40 yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 20, 1880

9. AGE (In years;

last birthday)

69

10. Under 1 Year

Months: Days

7

8

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Gerson Eiseman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. George B. Hess 8 E. Balto. St.

18. 450.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Anterior-sclerosis  
DUE TO

? yes

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Paralysis

9 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1923 to Mar. 1950, that I last saw the  
deceased alive on Mar. 28, 1950, and that death occurred at 6:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Mar. 30, 1950

Druid Ridge

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

David Sondheim &amp; Son 1902 Eutaw Pl.

VS 150

MAR 29 1950

David Sondheim &amp; Son - 837

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

ENCLOSING INK. E







MS--79805

50 2949

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2949

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Riepe

2. DATE  
OF  
DEATH

Mar. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR Baltimore City Hospitals

INSTITUTION 4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

26-12

D. STREET ADDRESS (If rural, give location)

Infirmary--4940 Eastern Ave.

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 27, 1868

9. AGE (In years last birthday)

81

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Fred Riepe

14. MOTHER'S MAIDEN NAME

Mary Baldis

15. WAS DECEASED EVER IN U. S. ARMOED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Records\* B.C.H.--4940 Eastern Ave.

18. 581-1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) A S C V D.

DUE TO

(C) Laennec's cirrhosis

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-13-1943 to 3-28-1950, that I last saw the deceased alive on 3-28-1950 and that death occurred at 1:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

4940 Eastern Ave.

3-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

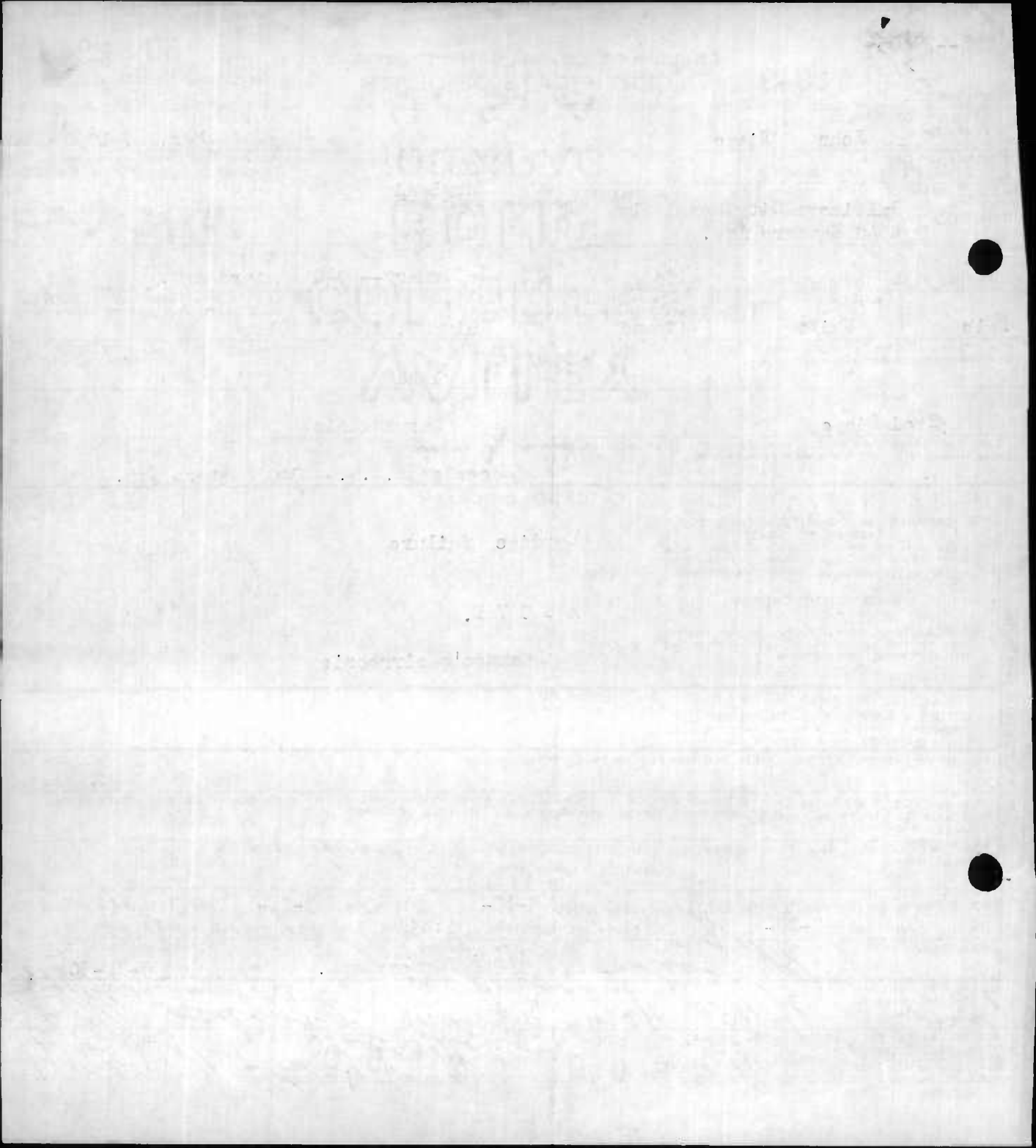
MAR 30 1950

Huntington Williams

1214 St Paul St

124a







00  
50 2950BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2950

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EMIL J. SHEK

2. DATE  
OF  
DEATH

Mar. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

600 East 30th St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

600 East 30th St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 9, 1883

9. AGE (in years  
last birthday)

66

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Produce business (R)

10B. KIND OF BUSINESS OR  
INDUSTRY

Sepl

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Fred Shek

14. MOTHER'S MAIDEN NAME

Kunagunda (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Marie G. Shek, 600 East 30th St.

18. 470.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary occlusion

3 days.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

None.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 3/25, 1950, to 3/28, 1950, that I last saw the deceased alive on 3/28, 1950, and that death occurred at 6:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 30 1950

Huntington Village

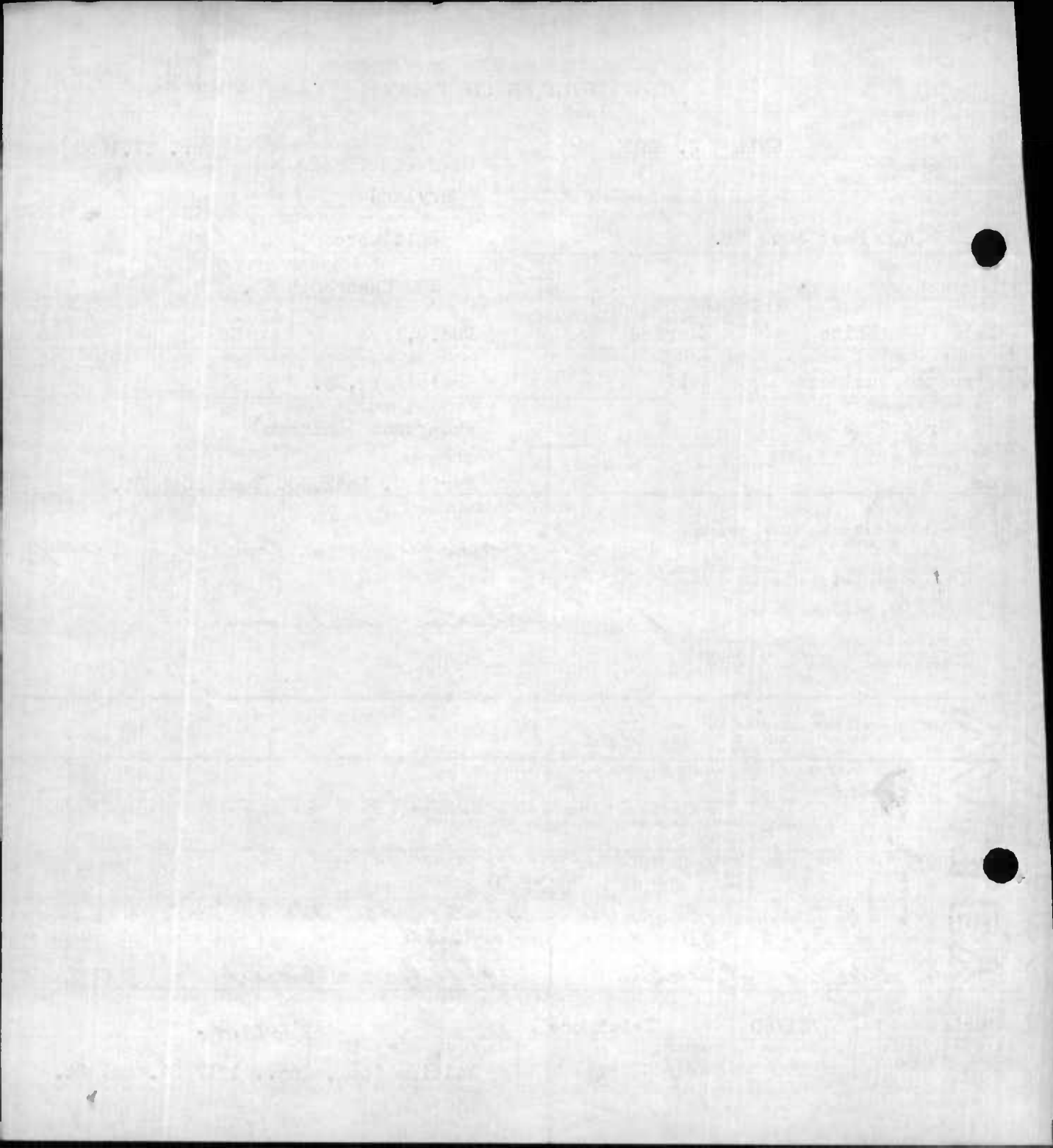
William Cook, Inc., 1217 St. Paul St.

VS 150

15661

94a







62  
50 2951BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2951  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>LUCY. A. SOLLERS</i>		2. DATE OF DEATH <i>3/28/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>13-02</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Maryland General</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt.</i>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>605 Lennox ST #17</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>12/5/68</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore MD</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John D Ford</i>		14. MOTHER'S MAIDEN NAME <i>Edith French</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>3740 Buch Ave</i>	
17. INFORMANT <i>Lucy A Sollers</i>		ADDRESS <i>3740 Buch Ave</i>	

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cardiac decompensation</i> DUE TO (B) <i>Myocardial infarction</i> DUE TO (C) <i>Pneumonia</i>	INTERVAL BETWEEN ONSET AND DEATH
---	---	----------------------------------

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/24</i> , 19 <i>50</i> , to <i>3/28</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/28</i> , 19 <i>50</i> , and that death occurred at <i>11:00</i> p. m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Charles J. Black</i>		23B. ADDRESS <i>Maryland General</i>		23C. DATE SIGNED <i>3/28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>		24B. DATE <i>4/1/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>		24E. FUNERAL DIRECTOR <i>William J. Williams</i>		24F. ADDRESS <i>1214 St Paul St</i>	



DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other		20. Signature of other	
21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	



460

50 2952

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2952

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BARBARA KELLER

2. DATE  
OF  
DEATH

Mar. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2225 Prentiss Place

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Oct. 16, 1858

9. AGE (in years  
last birthday)

91

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joshua Turner

14. MOTHER'S MAIDEN NAME

Rebecca (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Johanna Landon, 824 S. Clinton St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pneumonia

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)

Cal Rectum

8 months?

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1940 to 3/28, 1950 that I last saw the  
deceased alive on 3/27, 1950 and that death occurred at 3:15 AM, from the causes and on the date stated above.

23A. SIGNATURE

J. Karl Grossman

M. D.

23B. ADDRESS

1212 N. Patterson Pl. W.

23C. DATE SIGNED

3/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

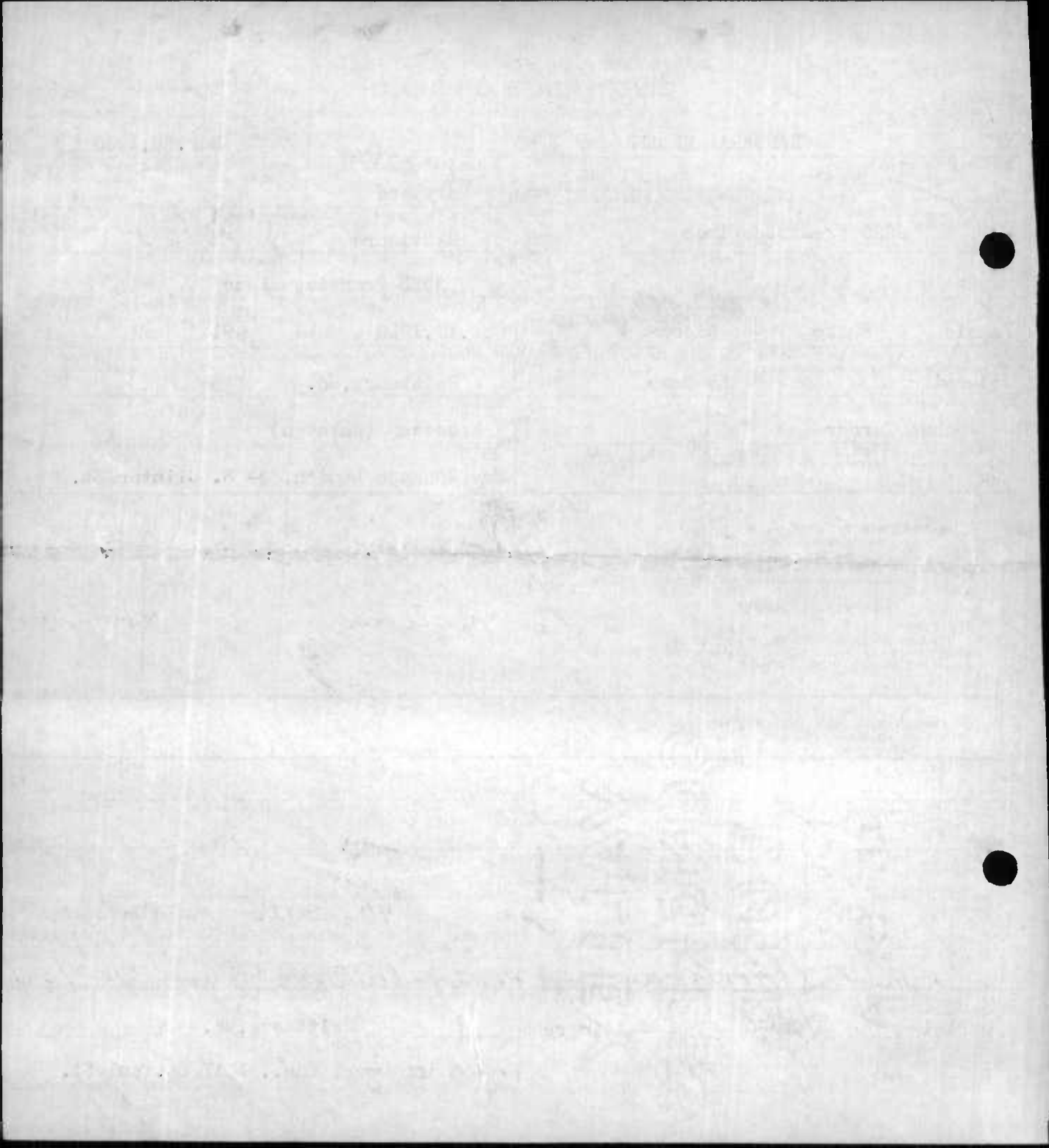
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.







100  
MS--74947CERTIFICATE CORRECTED 3-30-50  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2953  
Registered No.50 2953  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

Herman Pohle

2. DATE  
OF  
DEATH

Mar. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1010 Stiles St.-- (Infirmery)

c. Length of stay in Baltimore Most of life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Aug. 26, 1877  
1875?9. AGE (In years  
last birthday)

94? 72

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Henry

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records\* B.C.H.--4940 Eastern Ave.

18. 4700 1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-26-1942, to 3-28-1950 that I last saw the  
deceased alive on 3-28-1950 and that death occurred at 10:00 Am., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Ave.

3-28-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

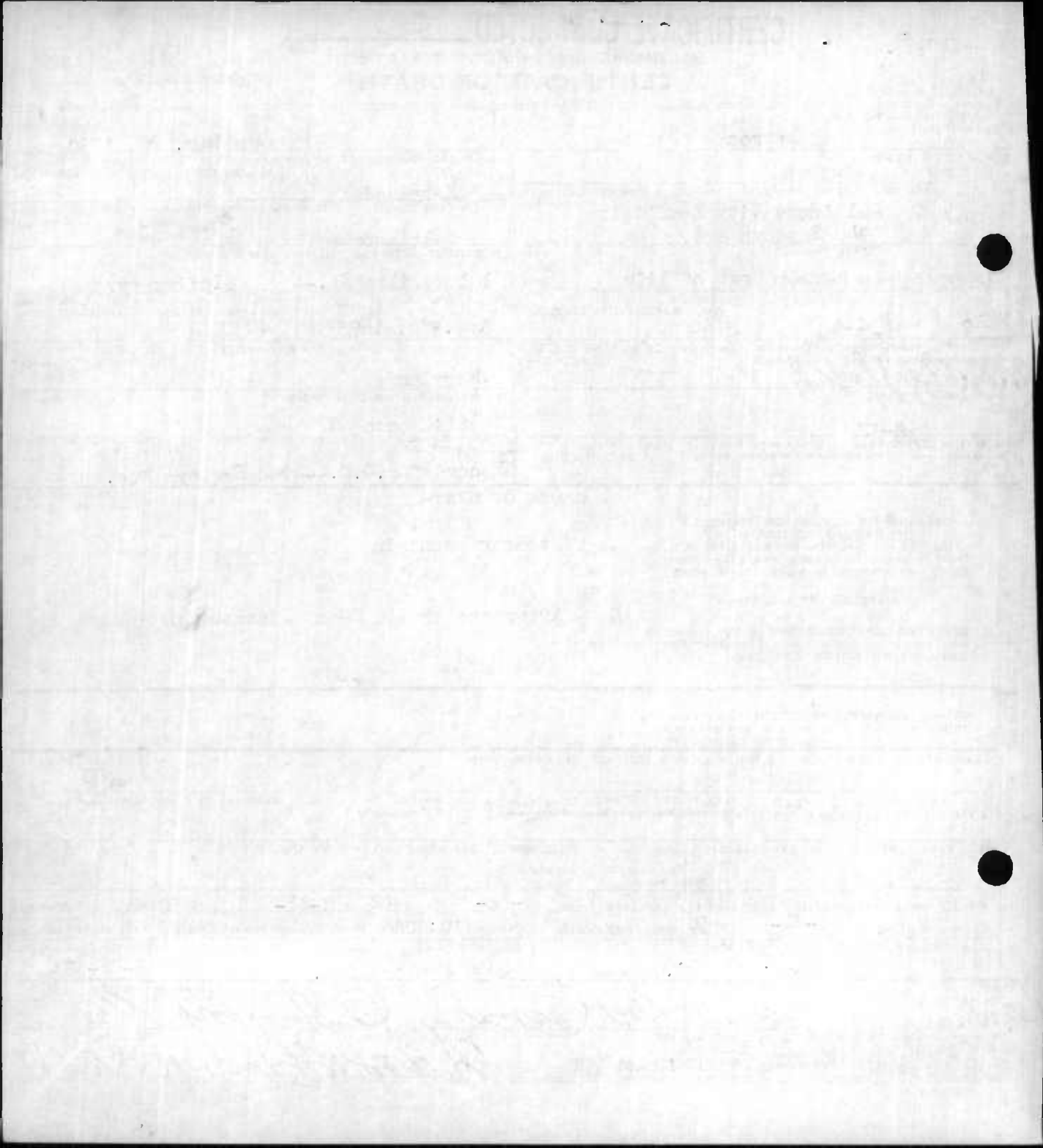
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS







460

50 2954

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2954

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Wesley B TAYLOR

2. DATE  
OF  
DEATH

MARCH 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Pinecrest Sanitarium  
620 Chapelgate Lane4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 9-05D. STREET ADDRESS (If rural, give location)  
1137 Homestead

C. Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 24 1873

9. AGE (In years  
last birthday)

77

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Express hauling

10B. KIND OF BUSINESS OR  
INDUSTRY

Own business

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? Taylor

14. MOTHER'S MAIDEN NAME

Agnes Boring

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Annie C Taylor (wife) 1137 Homestead

## CAUSE OF DEATH

18. 422.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Terminal lobar pneumonia  
DUE TO Lower lobe, RightINTERVAL BETWEEN  
ONSET AND DEATH

48 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Chronic myocardial degeneration  
DUE TO and myocarditis

?

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(C) Generalized arteriosclerosis  
Cerebral arteriosclerosis

?

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 21, 1950, to March 28, 1950, that I last saw the  
deceased alive on March 27, 1950, and that death occurred at 640 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Melvin N. Boden

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

3/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

March 31, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

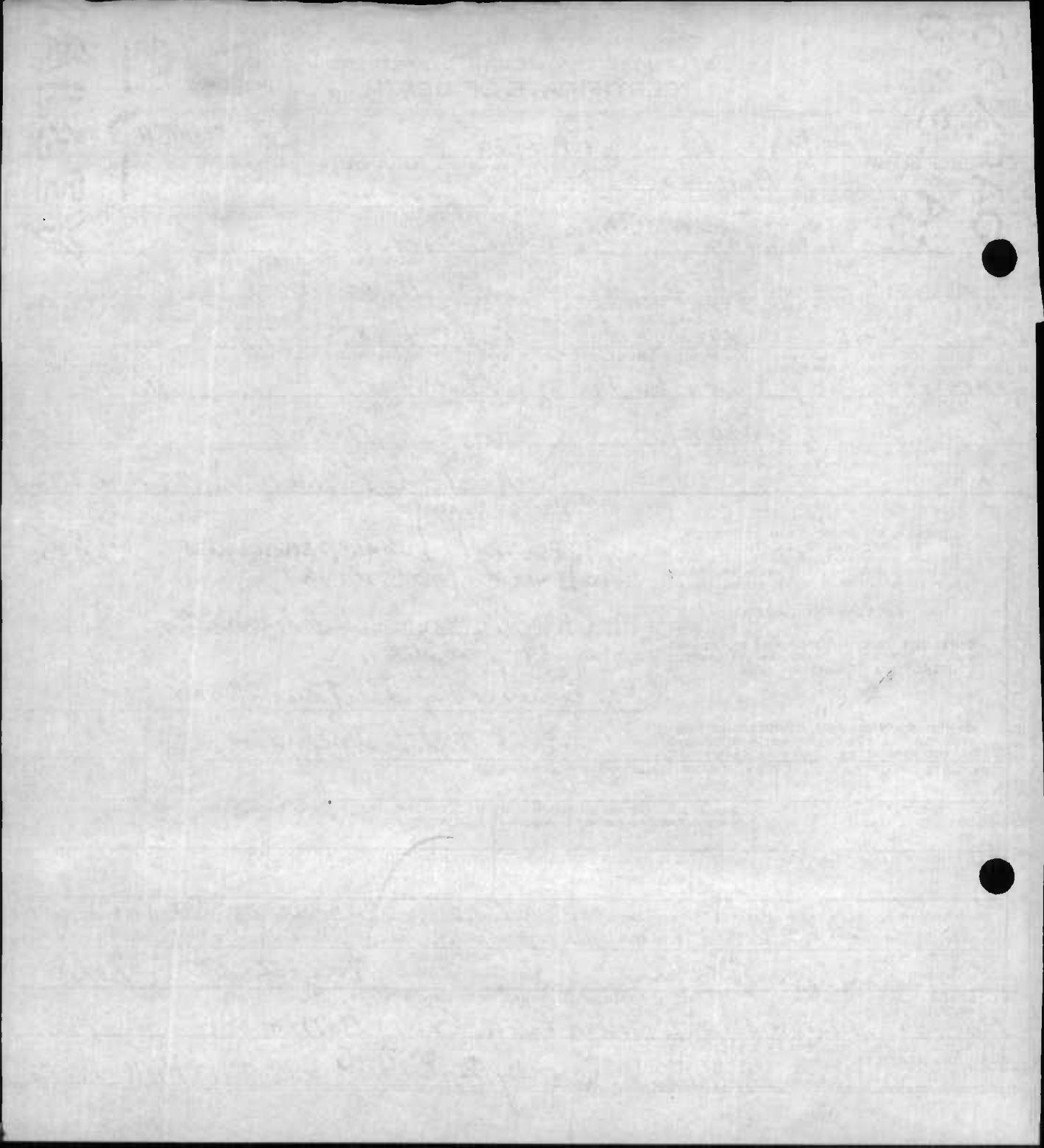
J. Melville Jenkins

ADDRESS

2713 Kirk Ave

MAR 30 1950







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2955

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Maggie Roberts

2. DATE  
OF  
DEATH

March 29 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

April 2-3-50

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

9-06

b. FULL NAME OF HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

d. STREET ADDRESS (If rural, give location)

1832 E 29th St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

Female

White

Widowed

6-6-77

73

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewife

Home

Balto. City

USA

13. FATHER'S NAME

Wm. Christian

14. MOTHER'S MAIDEN NAME

Rachel Huegel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 175X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of ovary

3-4 years

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

March 29, 1950

Carcinomatosis

YES ☒ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

OF INJURY

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-23-1950, to 3-29-1950, that I last saw the deceased alive on 3-29-1950, and that death occurred at 3:11 p.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

Ernest F. Latham

M. D.

JOHNS HOPKINS HOSPITAL

March 29, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

3-31-50

St. James

Mountain Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 30 1950

Ernest F. Latham

Ernest M. Brooks, Sparks, Md

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of other institution	
19. Signature of family		20. Signature of friends		21. Signature of neighbors	
22. Signature of community		23. Signature of church		24. Signature of school	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	



200

50 2956

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2956

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hannah E. Rich

2. DATE  
OF  
DEATH

Mar. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1134 N. Calhoun St.

C. Length of stay in Baltimore

35

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

Nov. 25, 1900

9. AGE (In years  
last birthday)

49

10. Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Samuel Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Elizabeth Monroe - 623 Cumberland

CUMBERLAND

18. 443 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Myocarditis

3 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension

Unknown

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-1-1944 to 3-29-1950, that I last saw the  
deceased alive on 3-28-1950, and that death occurred at 5 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Frank A. Saunders

M. D.

23B. ADDRESS

1029 N. Stricker St.

23C. DATE SIGNED

3-30-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B.

24B. DATE

4-2-50

24C. NAME OF CEMETERY OR CREMATORY

Young's Cem.

24D. LOCATION (City, town, or county)

Huntingtown - Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Whitehead, Jr.

25. FUNERAL DIRECTOR

ADDRESS

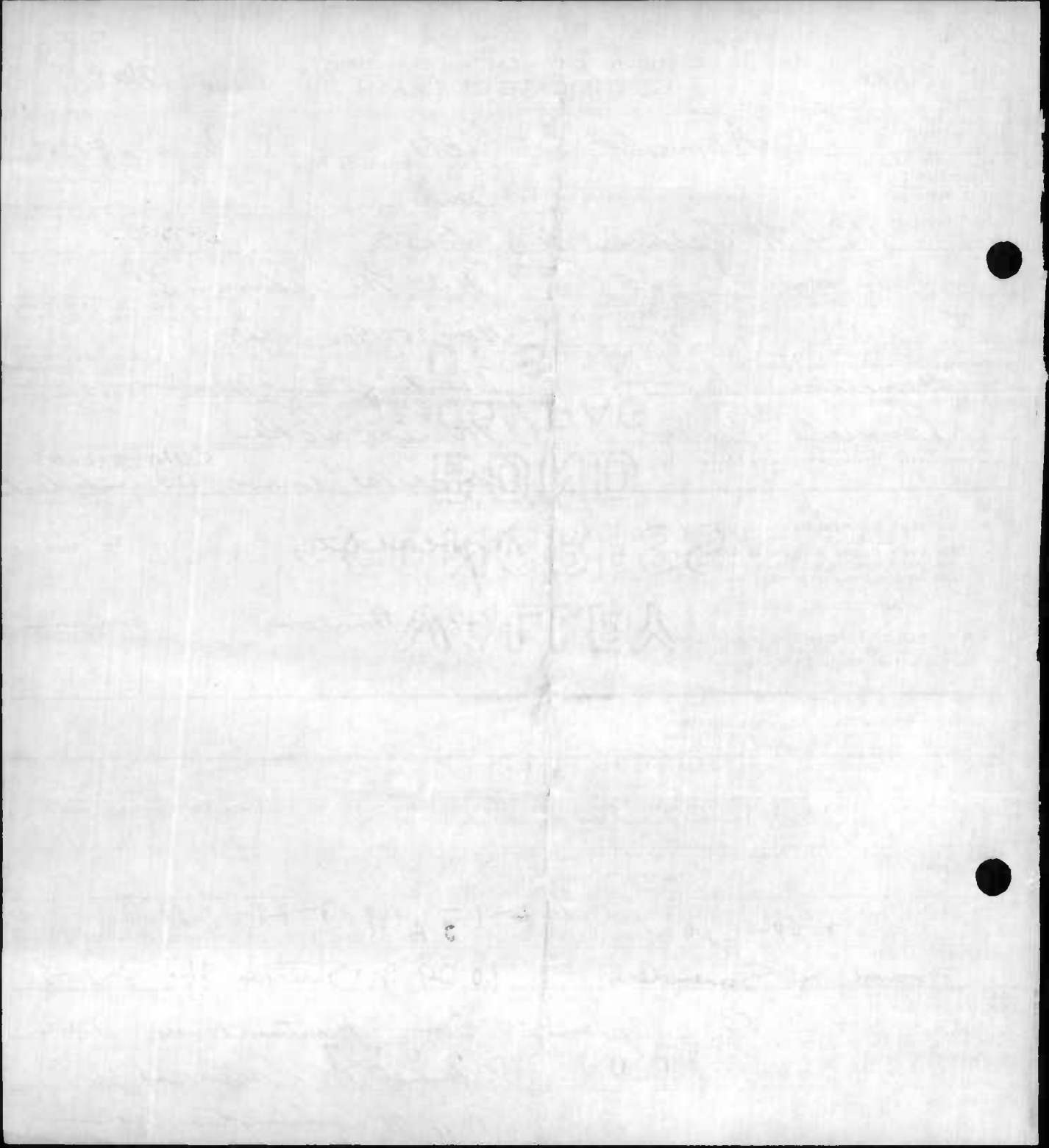
Samuel W. Sullivan, Jr.

VS 150

77087 1011 N. Calington Ave 921

MEDICAL CERTIFICATION







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2957

50 2957  
BIRTH NO.

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>John Randolph Moore</b>			2. DATE OF DEATH <b>3-27-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3834 Sequoia Ave.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>3834 Sequoia Ave.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>HOSPITAL OR INSTITUTION</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Md. 15-10</b>		
C. Length of stay in Baltimore <b>67yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>3834 Sequoia Ave.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-15-1882</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commerical Traveler</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>PAINT INDUSTRY Hanline Bros.</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Henry C. Moore</b>			14. MOTHER'S MAIDEN NAME <b>Frances F. Dahle</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-3529</b>	17. INFORMANT ADDRESS <b>Laura Catherine Moore</b>		

18. <b>4221</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic-Cardio-Vascular Disease</b> (B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **December, 1947** to **3-27**, 19**50**, that I last saw the deceased alive on **3-27, 1950**, and that death occurred at **3:20 P. M.**, from the causes and on the date stated above.

22A. SIGNATURE <b>William H. Fusting</b>	22B. ADDRESS <b>11 S. Chase St.</b>	22C. DATE SIGNED <b>3-30-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-30-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>	REGISTRAR'S SIGNATURE <b>W. H. Fusting</b>	25. FUNERAL DIRECTOR ADDRESS <b>2 E. South Annacost 5118 Gwynn Oak Ave</b>
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**27815**

**937**

MEDICAL CERTIFICATION







250

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2958

BIRTH NO. 2958

1. NAME OF DECEASED (Type or Print) <b>GEORGE Dewey DAWSON</b>		2. DATE OF DEATH <b>March 29, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>B Hotel, 811 E. Baltimore St.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>3-02</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>		8. DATE OF BIRTH <b>July 27 - 1898</b>	
9. AGE (In years last birthday) <b>51</b>		10. Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cook Rest</b>	
11. BIRTHPLACE (State or foreign country) <b>Buckingham West Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Washington Dawson</b>		14. MOTHER'S MAIDEN NAME <b>Artishie West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>236-12-2207</b>	
17. INFORMANT <b>Ward</b>		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>E903.6, Subdural hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Chronic alcoholism</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>Partial</b> <input type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Hotel</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>B Hotel, 811 E. Baltimore St.</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>March 21, 1950 6:30 P.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Slipped and fell in hall</b>	
I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>H. J. Mc Clafferty</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>March 29, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>3/30/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bellevue</b>	
24D. LOCATION (City, town, or county) <b>West Va.</b>		24E. FUNERAL DIRECTOR <b>Carroll &amp; Co.</b>		24F. ADDRESS <b>403 E. 25th St.</b>	

151 N-854.1 72071 403 E. 25th St. 186a



CERTIFICATE OF DEATH

ATTESTED BY THE DEPARTMENT OF HEALTH

DATE

NAME

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH



526

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

50 2959

Registered No. \_\_\_\_\_

50 2959

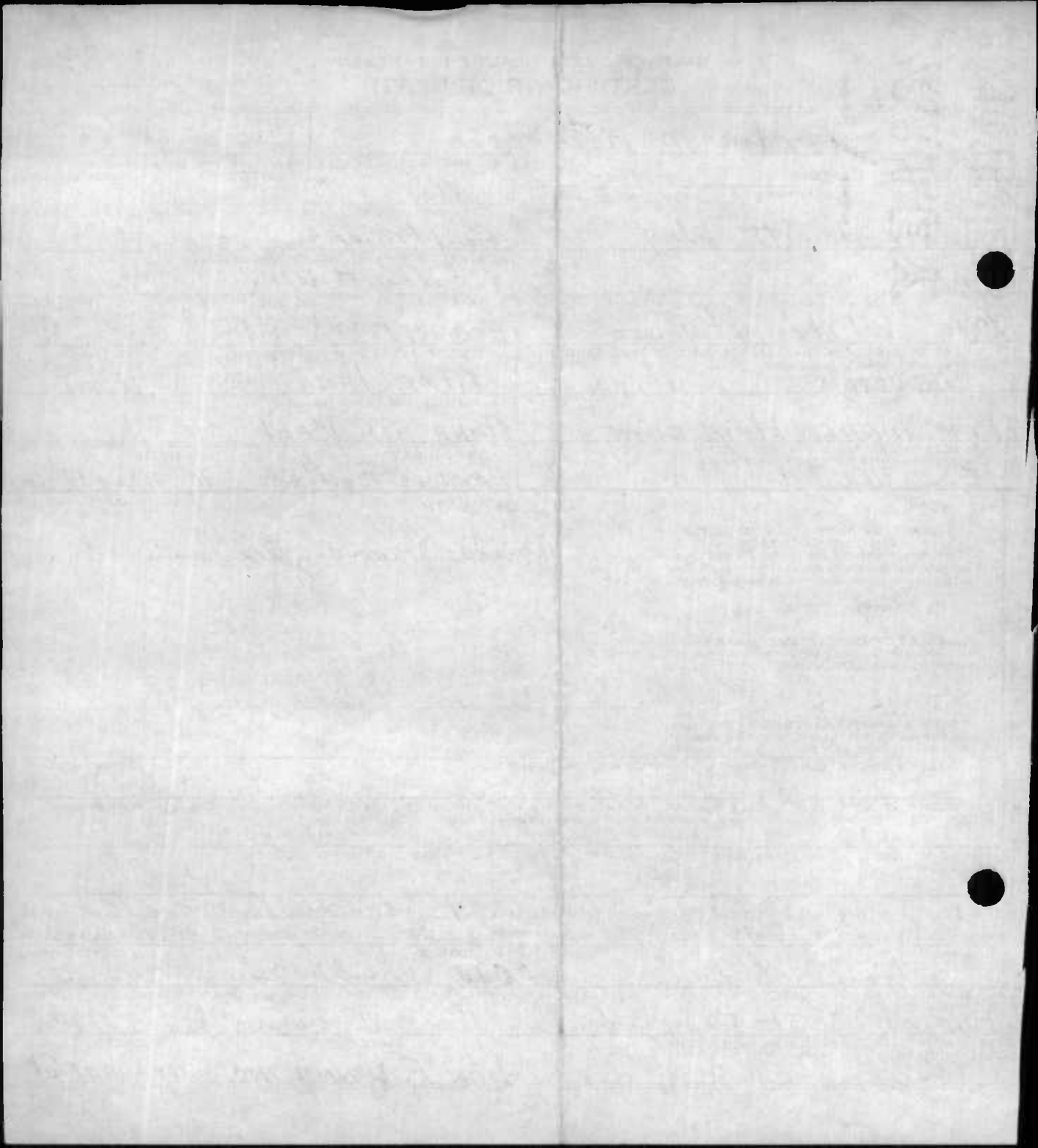
1. NAME OF DECEASED (Type or Print) <b>Ferdinand Heinegger</b>		2. DATE OF DEATH <b>3-28-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>751 Hewitt Way</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-04A</b>	
D. STREET ADDRESS (If rural, give location) <b>901 Hewitt Way</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb 19, 1897</b>	
9. AGE (In years last birthday) <b>53</b>		10. Under 1 Year Months: Days Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ferdinand Heinegger</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Beck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES WW#1</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>FRANCES Behlert</b>		ADDRESS <b>901 Hewitt Way</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion 1 hr.</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>March 27, 1950</b> , to <b>March 28, 1950</b> , that I last saw the deceased alive on <b>March 27, 1950</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Carol Gordon</b>		23b. ADDRESS <b>5023 Wright Ave</b>	
23c. DATE SIGNED <b>3-29-50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>3-31-50</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		24d. LOCATION (City, town, or county) (State) <b>Dogwood Rd MD</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>		REGISTRAR'S SIGNATURE <b>John F. Denny Inc.</b>	
25. FUNERAL DIRECTOR <b>John F. Denny Inc.</b>		ADDRESS <b>715 LIGHT ST.</b>	

MEDICAL CERTIFICATION

10247

94a



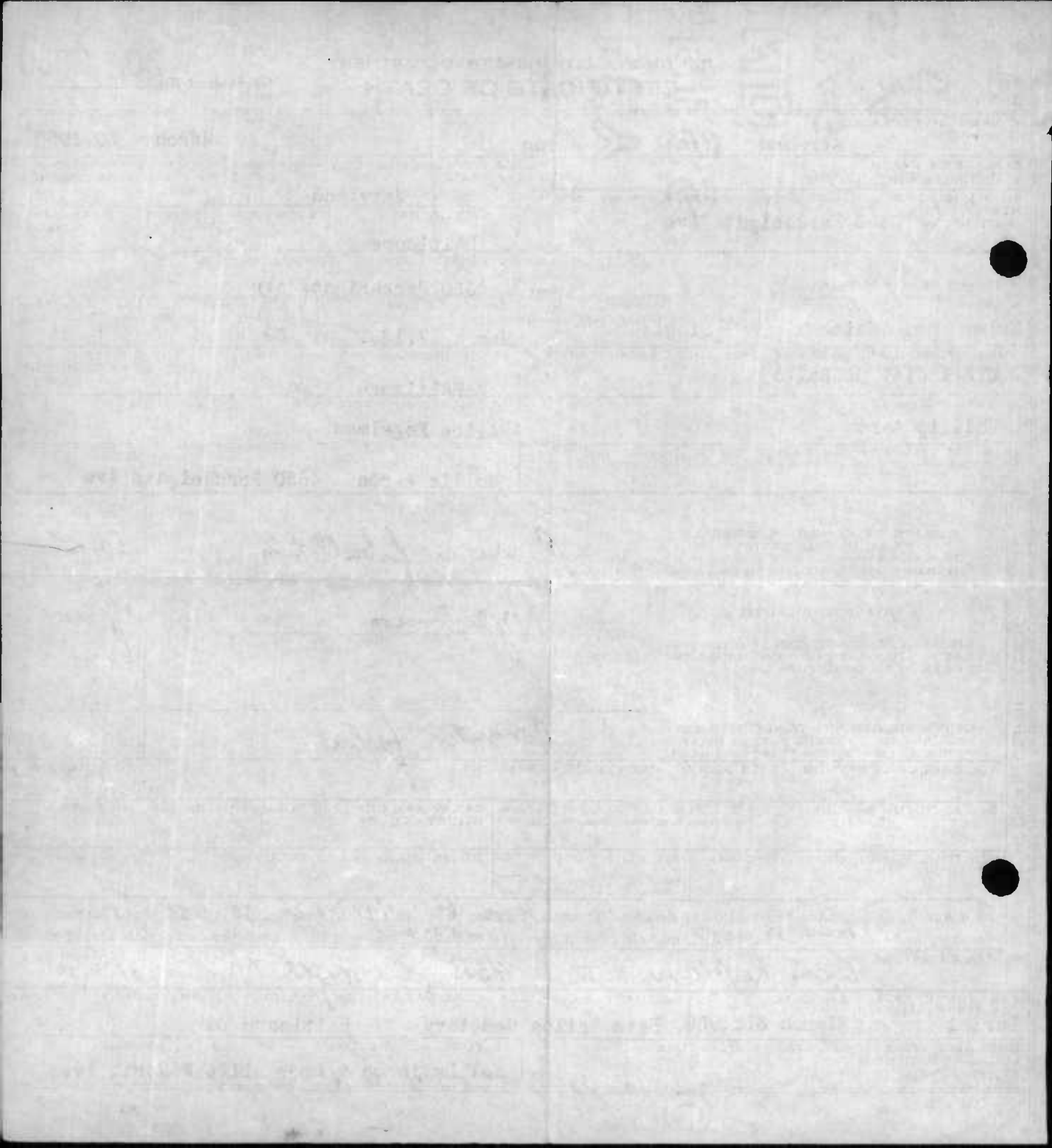




650  
50 2960  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2960  
Registered No.

1. NAME OF DECEASED (Type or Print) Abraham Israel Aaron			2. DATE OF DEATH March 30, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 4650 ParkHeights Ave			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-16		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 4650 ParkHeights Ave		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 17, 1891	9. AGE (In years last birthday) 59	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk City of Balto		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Phillip Aaron			14. MOTHER'S MAIDEN NAME Alice Fogelman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mollie Aaron 4650 ParkHeights Ave	
18. 444 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Atrial fibrillation DUE TO (B) Hypertension DUE TO (C) Congestive failure INTERVAL BETWEEN ONSET AND DEATH 5 months 2 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from November, 1949 to March 30, 1950, that I last saw the deceased alive on March 30, 1950, and that death occurred at 4:30 a.m., from the causes and on the date stated above.					
23A. SIGNATURE Louis R. Masen M.D.		23B. ADDRESS 4535 Park Heights Ave		23C. DATE SIGNED 3/30/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 31, 1950		24C. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR MAR 30 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros 1124 W North Ave	







520

BIRTH NO. 50 2961

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

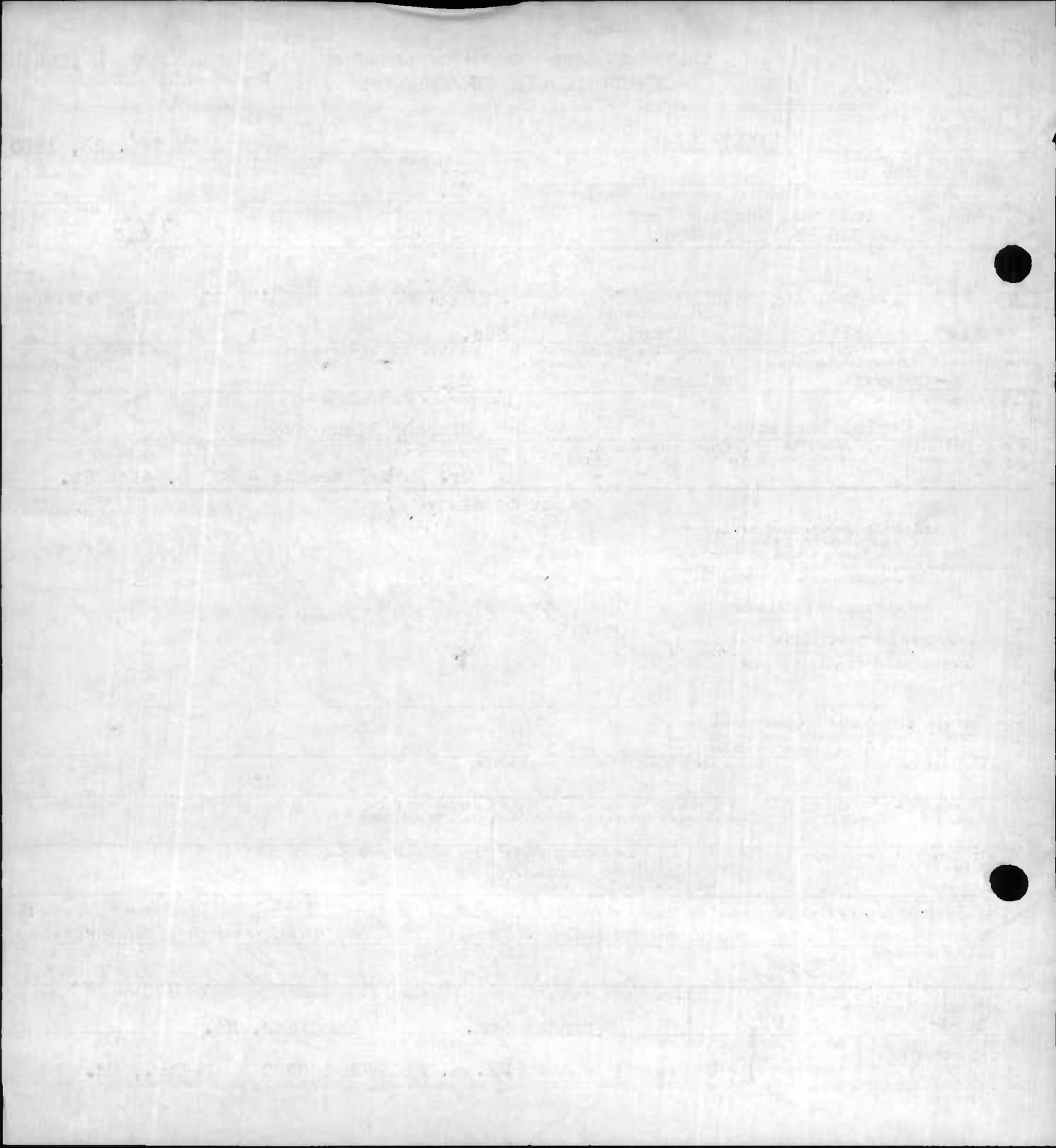
Registered No. 50 2961

1. NAME OF DECEASED (Type or Print) <b>LILLIE LINK</b>		2. DATE OF DEATH <b>Mar. 28, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Anderson Nursing Home</b> <b>3605 Hillsdale Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore</b> <b>15-08A</b>	
D. STREET ADDRESS (If rural, give location) <b>3517 Liberty Hgts. Ave.</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Dec. 1968</b>
9. AGE (In years last birthday) <b>81</b>	10. UNDER 1 YEAR Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
13. FATHER'S NAME <b>Daniel Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Richardson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>Mr. Daniel Meades - 501 E. 41st St.</b>	

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Cerebral hemorrhage (left side) 2 days.</b> DUE TO <b>hypertension.</b> (B) <b>Congestive Pneumonia - 2 days.</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3-25</b> , 1950, to <b>3-27</b> , 1950, that I last saw the deceased alive on <b>3-26</b> , 1950, and that death occurred at <b>1 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Frank H. Warner</b>		23B. ADDRESS <b>2604 Garrison Blvd.</b>		23C. DATE SIGNED <b>3-28-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/31/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>		REGISTRAR'S SIGNATURE <b>William J. Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. J. TICKNER &amp; SONS Balto., Md.</b>	







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2962

Registered No. \_\_\_\_\_

50 2962

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>FREDERICK ERNEST PAUSCH</b>		2. DATE OF DEATH <b>MARCH 29, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3606 ROSEDALIE RD.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 15-11</b>	
5. Length of stay in Baltimore <b>LIFE.</b>		6. STREET ADDRESS (If rural, give location) <b>3606 ROSEDALIE ROAD</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>	8. DATE OF BIRTH <b>APRIL 28, 1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLAIM DEPT (Att'y) INSURANCE CO.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CASUALTY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FREDERICK R. PAUSCH</b>		14. MOTHER'S MAIDEN NAME <b>ERNESTINE FRIEBERTSHAUSER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknowns) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-3583</b>	
17. INFORMANT <b>WIFE</b>		ADDRESS <b>MRS. FRED. PAUSCH, 3606 ROSEDALIE RD.</b>	

18. <b>157X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) CARCINOMA - PANCREAS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>
<p align="center"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>		
19A. DATE OF OPERATION <b>DEC. 31, 1949</b>		19B. MAJOR FINDINGS OF OPERATION <b>CA-PANCREAS &amp; METASTASIS</b>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>N/O</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>DEC. 1949</b> to <b>MAR. 29, 1950</b> that I last saw the deceased alive on <b>MAR. 25, 1950</b> and that death occurred at <b>7:00 a.m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>Arthur Karfain</b>		23B. ADDRESS <b>4230 Fork Raven Blvd.</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial--</b>		24B. DATE <b>3/31/50</b>
24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>		25. FUNERAL DIRECTOR <b>WM. J. TICKNER &amp; SONS</b>
REGISTRAR'S SIGNATURE <b>Huntington Hill</b>		ADDRESS <b>Balto., Md.</b>

MEDICAL CERTIFICATION

V2680

469



SEBASTIAN  
VALLEY  
CONCRETE



265  
50 2963BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2963

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret E. McCormick,

2. DATE  
OF  
DEATH

March 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3512 Spaulding Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

Baltimore,

D. STREET ADDRESS (If rural, give location)

3512 Spaulding Ave.,

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE. MARRIED.  
WIDOWED. DIVORCED (Specify)

widow

8. DATE OF BIRTH

ABOUT Aug. 6, 1864

9. AGE (In years;  
last birthday)

ABOUT 85

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Sexton,

14. MOTHER'S MAIDEN NAME

First name unknown, last name..Hopkins.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. F.E. Sahlin, 3512 Spaulding Ave.

18. 410 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cardiac Decompression  
Chronic Mitral Endocarditis1 mo  
unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE, (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arterio Sclerosis  
Hypertension

unknown

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Advanced Age

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1949 to March 29, 1950 that I last saw the deceased alive on March 28, 1950 and that death occurred at 6:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

G.B. Euser

M. D.

23B. ADDRESS

7201 York Rd

23C. DATE SIGNED

3-29-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

April 1, 1950

24C. NAME OF CEMETERY OR CREMATOR

Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

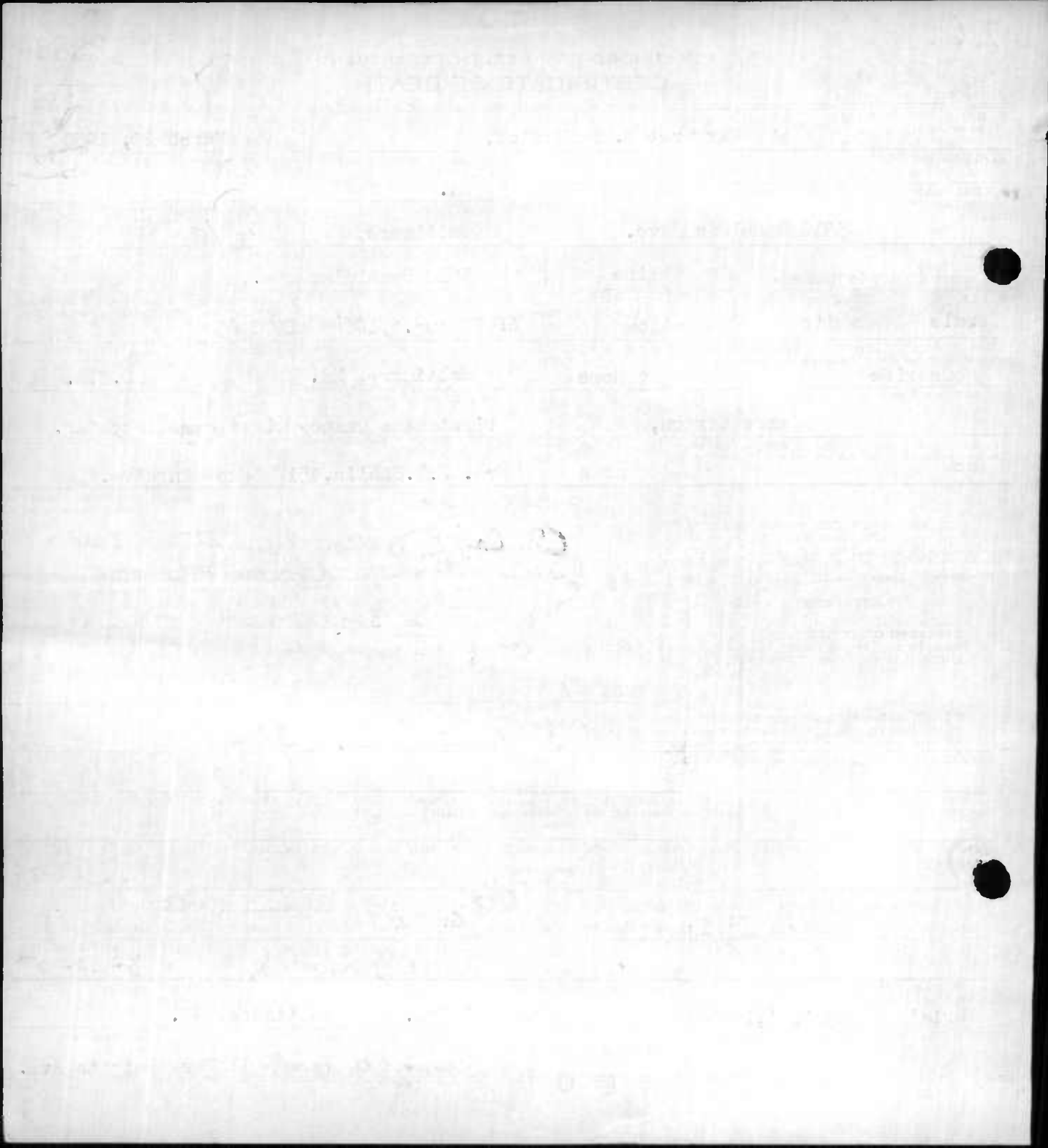
Margaret E. McCormick

25. FUNERAL DIRECTOR

ADDRESS

4611 Park Heights Ave.







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2964

Registered No. \_\_\_\_\_

452  
50 2964

1. NAME OF DECEASED (Type or Print) <u>Katherine Alma. HOLMES</u>		2. DATE OF DEATH <u>3/28/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Doa University Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lake Shore, Pasadena, Maryland</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Pasadena</u>	
D. STREET ADDRESS (If rural, give location) <u>-</u>			
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov 4 1875</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>74</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>-</u>	
13. FATHER'S NAME <u>Thomas Hugh Curley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cartwright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
		INFORMANT <u>Mrs. Helen Reed</u> <u>Daughter</u>	
		ADDRESS <u>1432 E. Elm St.</u>	

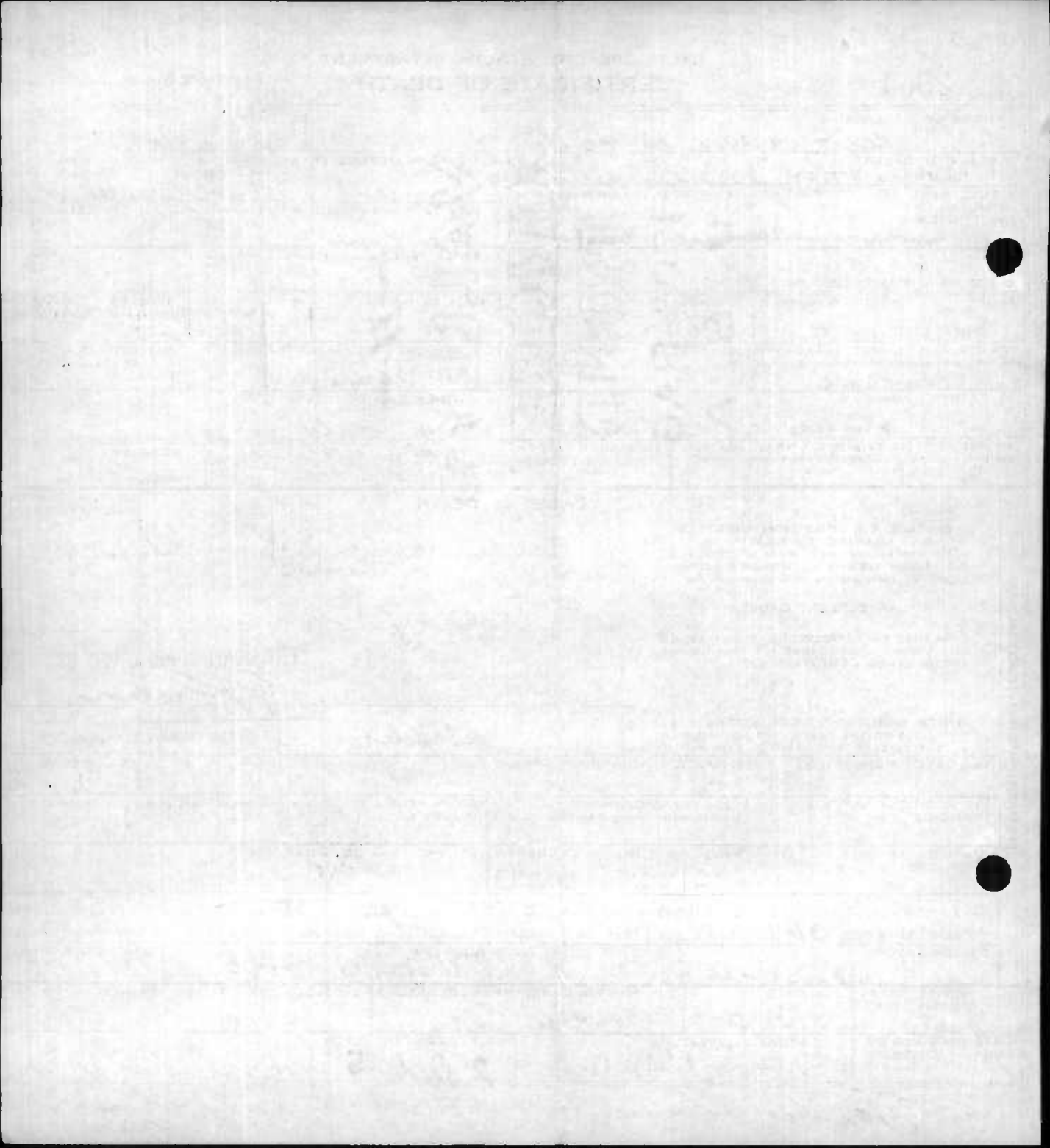
18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Pulmonary Embolism?</u> DUE TO		CERTIFICATION APPROVED BY <u>RBFisher</u> M. D. CHIEF OR ASST. MEDICAL EXAMINER	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>obesity</u>			
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>-</u>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I hereby certify that I attended the deceased from <u>3/20/50</u> , 19 <u>50</u> , to <u>3/28</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>50</u> , and that death occurred at <u>3:00 P.m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>Mark E. Hall</u>		23B. ADDRESS <u>407 Md Hosp</u>	23C. DATE SIGNED <u>3/28/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>3-31-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL CEM.</u>	24D. LOCATION (City, town, or county) (State) <u>CITY</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 30 1950</u>		25. FUNERAL DIRECTOR <u>WIEDEBOLD SON - GREENMOUNT AVE 22ND</u>	

MEDICAL CERTIFICATION

VS 150

*See in church & asked by Medical Exam 937*







T-220  
B-200 50 2965BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2965  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JENNY TOSCHES (BECCIO)

2. DATE  
OF  
DEATH

3/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

236 S. ROBINSON ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE 1-02

D. STREET ADDRESS (If rural, give location)

236 S. ROBINSON ST.

Length of stay in Baltimore

33

Yrs.  
Mons.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

FEB. 18, 1874. 76 YRS

9. AGE (In years  
last birthday)10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF  
WHAT COUNTRY?

ITALY

13. FATHER'S NAME

GIUSEPPE TOSCHES

14. MOTHER'S MAIDEN NAME

ANNA ANDREOLA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MARY TROTTA 236 S. ROBINSON ST.

18. 4 yrs. 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(A) ARTERIOSCLEROTIC CARDIO-  
DUE TO VASCULAR DISEASE

(B) GENERALIZED ARTERIOSCLEROSIS

DUE TO

(C)

UNKNOWN

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 1950, to MARCH 29, 1950, that I last saw the  
deceased alive on MARCH 29, 1950, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Henry J. Houska

M. D.

23B. ADDRESS

333 S. East Ave.

23C. DATE SIGNED

3/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 3-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem

24D. LOCATION (City, town, or county)

4430 Belair Rd. Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Henry J. Houska

25. FUNERAL DIRECTOR

ADDRESS

Frankella House 3225 High St



4904

АНАНАС

23H0207 3493042



Dr. Koors  
1202 ST. Paul  
50 2966

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2966  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph STANLEY Grossman - Sr.

2. DATE  
OF  
DEATH

3/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

8. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1631 CARSWELL ST.

C. CITY OR TOWN

BAITIMORE

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1631 CARSWELL STREET

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

MAR. 26-1891

9. AGE (In years  
last birthday)

59

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR  
INDUSTRY

CAMBRIDGE Tailor

11. BIRTHPLACE (State or foreign country)

BAITIMORE Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JAMES Grossman

14. MOTHER'S MAIDEN NAME

MARY Neumann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

216-05-6035

17. INFORMANT

ADDRESS

Mrs. Regina Grossman - 1631 CARSWELL

1B. 420-1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Coronary Disease  
cardiovascular disease.  
Coronary Thrombosis.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

3 mo  
1 yr  
10 min

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
WORK ☐

22. I hereby certify that I attended the deceased from Jan 3, 1950, to March 29, 1950, that I last saw the  
deceased alive on 3/29, 1950, and that death occurred at 12:19 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 30 1950

Leonard J. Buck - 5305 Harford Rd.

VS 150

36006

937



1-1-1964  
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1-1-1964



Dr. Messina

1403 S. Charles

D-220 50 2967

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

50 2967  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alice V. Dicus

2. DATE  
OF  
DEATH

8/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3133 Northway drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 27-05

D. STREET ADDRESS (If rural, give location)

3133 Northway drive

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months; DaysIf Under 24 Hours  
Hours; Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Alice M. Patch - 3133 Northway

18. 430.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Arteriosclerotic Heart Disease

10 yrs

## ANTECEDENT CAUSES

DUE TO

Diabetes mellitus

10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Coronary Thrombosis

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 6/1, 1940 to 3/28, 1950 that I last saw the  
deceased alive on 3/28, 1950 and that death occurred at 2P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Vincent M. Messina M. D.

1403 S. Charles St

3/30/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/31/50

Woodlawn

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 30 1950

William M. L. Luck

5305 Harford Road



Dear Sir,  
I have the pleasure to inform you that the  
order for the purchase of the  
quantity of goods mentioned in the  
order is now being prepared and will be  
sent to you as soon as possible.  
Yours faithfully,  
J. H. [Signature]  
[Name]  
[Address]  
[City]



520  
MS-136726  
50 2968  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2968  
Registered No.

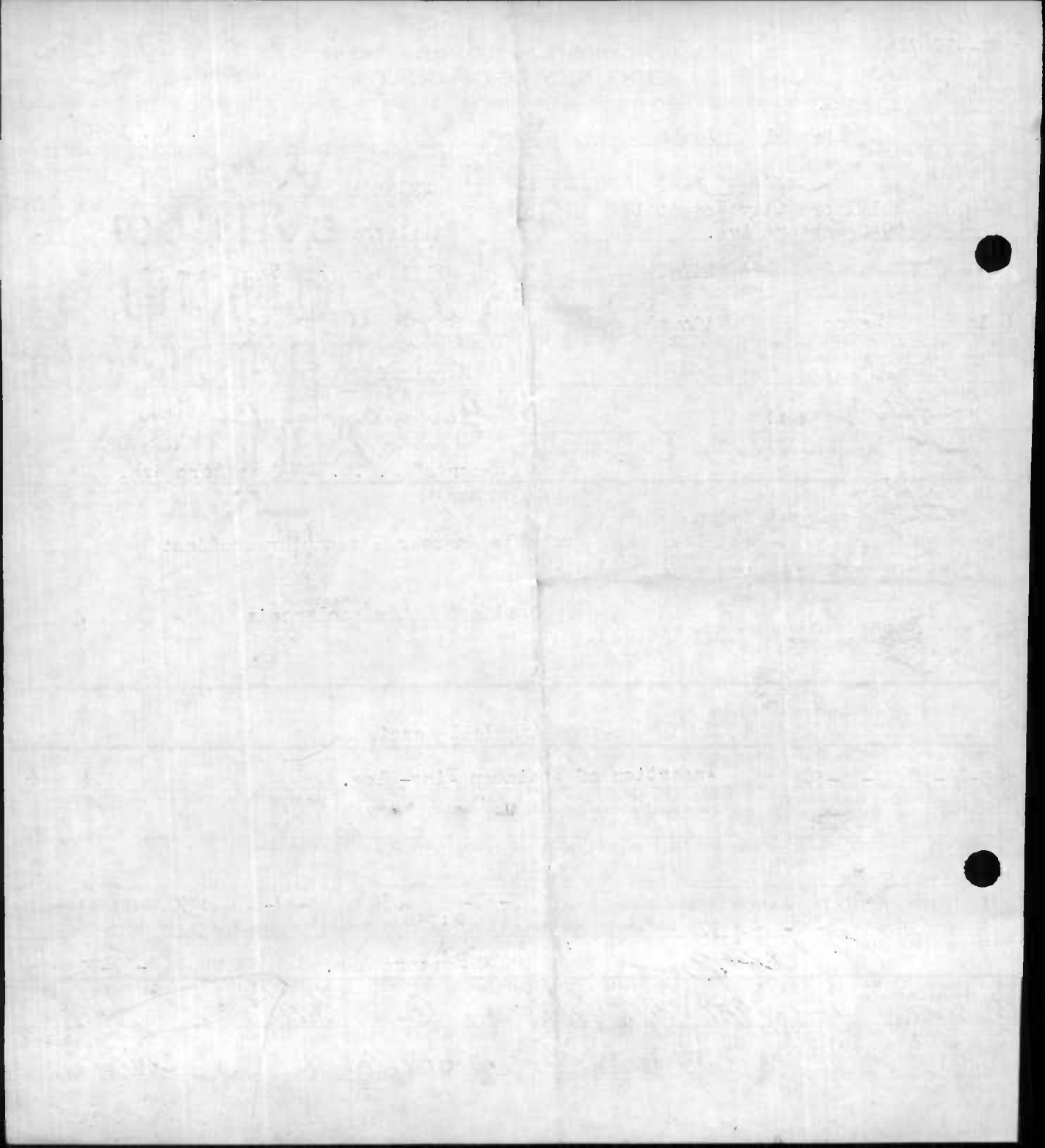
1. NAME OF DECEASED (Type or Print) <b>Richard Jones</b>			2. DATE OF DEATH <b>Mar. 29, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>18-02</b>		
Length of stay in Baltimore <b>life</b>			D. STREET ADDRESS (If rural, give location) <b>1131 Saratoga St. Zone 23</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 4, 1884</b>		9. AGE (In years last birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Joseph Jones?</b>			14. MOTHER'S MAIDEN NAME <b>Georgiana Burton.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records* B.C.H. 4940 Eastern Ave.</b>	

18. <b>331X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Probable cerebral vascular accident</b>		
DUE TO				
ANTECEDENT CAUSES		(B) <b>Generalized arteriosclerosis</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Large inguinal hernia</b>		

19A. DATE OF OPERATION <b>3-24-50 3-28-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Insertion of Steinman Pins- leg.</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3-21-</b> 1950, to <b>3-29-</b> 1950, that I last saw the deceased alive on <b>3-29-</b> 1950, and that death occurred at <b>2:35 P. m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>3-30-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-3-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cem Balto</b>	24D. LOCATION (City, town, or county) (State) <b>Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR <b>Mr. Kate R. Williams</b>	ADDRESS <b>322 N Schenck St</b>







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2969  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LINDA LORRAINE HUGHES

2. DATE  
OF  
DEATH

March 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

43 South Baltimore General Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan. 8, 1930

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days

2 21

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Hughes

14. MOTHER'S MAIDEN NAME

Connie Mosley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Connie Davis

ADDRESS

Ferndale Md.

18. 422.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Interstitial pneumonitis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Interstitial myocarditis

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

W. J. McCafferty

23B. CHIEF MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAMINER  
MEDICAL INVESTIGATOR

23C. DATE SIGNED

3/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS







200

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2970

50 2970  
BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) <b>WILHELMINA LOESCHKE</b>		2. DATE OF DEATH <b>3/29/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>BALTO</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <b>106 MALLORY HILL RD.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>BALTO 28-04</b>	
6. Length of stay in Baltimore <b>LIFETIME</b>		D. STREET ADDRESS (If rural, give location) <b>106 MALLORY HILL RD.</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>WHT</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>OCT 24 1858</b>
10A. USUAL OCCUPATION (Give kind of work done during last 12 months, or if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, birthday) <b>91 92</b>
13. FATHER'S NAME <b>NOT KNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
17. INFORMANT <b>MR PAUL LOESCHKE</b>		ADDRESS <b>60 DENNY ST.</b>	

18. **420.0**  
I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Arteriosclerotic Heart Disease**  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH  
**about 10 yrs**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
21D. TIME (Month) (Day) (Year) (Hour) INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June**, 19**47** to **March**, 19**50**, that I last saw the deceased alive on **March 26**, 19**50**, and that death occurred at **12:50 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Leo J. Gara** M. D. 23B. ADDRESS **1 Mallory Hill Rd Baltimore, Md** 23C. DATE SIGNED **3/30/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **4/1/50** 24C. NAME OF CEMETERY OR CREMATORY **BRUID RIDGE** 24D. LOCATION (City, town, or county) (State) **PIKESVILLE MD.**

DATE RECEIVED BY LOCAL REGISTRAR **MAR 30 1950** REGISTRAR'S SIGNATURE **Geo. Leimbach** 25. FUNERAL DIRECTOR **Geo. Leimbach** ADDRESS **12 W. N. Lynaugh St.**



WILLIAM A. REESCHKE

1941

IN

THE UNIVERSITY OF CHICAGO

LIBRARY

WILLIAM A. REESCHKE

1941

LIBRARY

WILLIAM A. REESCHKE

1941

MR. WILLIAM A. REESCHKE

WILLIAM A. REESCHKE  
1941

WILLIAM A. REESCHKE

WILLIAM A. REESCHKE

1941

WILLIAM A. REESCHKE

MR. WILLIAM A. REESCHKE



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2971

BIRTH NO. 50 2971

1. NAME OF DECEASED  
(Type or Print)

WILTON SNOWDEN, JR.

2. DATE  
OF  
DEATH

Mar. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

12 E. 33rd St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

12 E. 33rd St.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec. 13, 1884

9. AGE (In years-  
last birthday)

65

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Lawyer

10B. KIND OF BUSINESS OR  
INDUSTRY

Fidelity &amp; Deposit Co. Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wilton Snowden

14. MOTHER'S MAIDEN NAME

Adelaide D. Vail

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lucy H. Snowden

12 E. 33rd St.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myocardial Insufficiency.

2 yrs.

DUE TO

Arteriosclerosis.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Emphysema  
Chr Bronchitis Cor Pulmonale.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/30/48, 19 to Mar 28, 1950, that I last saw the  
deceased alive on Mar 28, 1950, and that death occurred at 2:55 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Halter L. Winkenwerder  
M.D.

23B. ADDRESS

1014 4th Lane St.

23C. DATE SIGNED

3/30/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

Arlington National Cem.

24D. LOCATION (City, town, or county)

Arlington, Va.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER &amp; SONS

Balto., Md.

VS 150

Halter L. Winkenwerder

V2680

2971

93D



DECLARATION OF ESTATE

100% S.A.

100% S.A.

100% S.A.

WATLEY

100% S.A.

100% S.A.

100% S.A.



+624

50 2972

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2972

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Anna K. Marshall</i>		2. DATE OF DEATH <i>3-27-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>3118 Barclay St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore</i> <i>12-02</i>	
c. Length of stay in Baltimore <i>45 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>3118 Barclay St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>12-16-1893</i>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>56</i>
13. FATHER'S NAME <i>Charles Addison</i>		12. CITIZEN OF WHAT COUNTRY? <i>Maryland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Holley</i>
17. INFORMANT <i>Susi Johnson</i>		ADDRESS <i>3118 Barclay St</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i> DUE TO <i>Thrombosis Left</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertension</i> DUE TO <i>Hypertension</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <i>Coronary Thrombosis</i> <i>Thrombosis Left</i> <i>Hypertension</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>3 year</i> <i>15 yr</i>
--	---	---

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>June 1940</i> , to <i>March 27, 1950</i> that I last saw the deceased alive on <i>March 27, 1950</i> , and that death occurred at <i>7P</i> m., from the causes and on the date stated above.				
23A. SIGNATURE <i>Herbert M. Fisher</i>		23B. ADDRESS <i>2824 St. Paul St</i>	23C. DATE SIGNED <i>3/28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-31-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cem</i>	24D. LOCATION (City, town, or county) (State) <i>A. A. Co MD</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 30 1950</i>		REGISTRAR'S SIGNATURE <i>Raymond Sanders</i>		
VS 150		ADDRESS <i>1412 E Preston St 94a</i>		



CERTIFICATE OF DEATH

Name of Deceased		Age	
Sex		Race	
Date of Death		Place of Death	
Cause of Death		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Entry		Place of Entry	



PLEASE WRITE PLAINLY, IN UNFADING INK. DO NOT WRITE IN RED INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

300  
50 2973

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2973  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) Horace Wade 2. DATE OF DEATH March 25, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 622 Laurens St USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE md B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location) 622 Laurens St C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 14-03

D. STREET ADDRESS (If rural, give location) 622 Laurens St

c. Length of stay in Baltimore

5. SEX M 6. COLOR OR RACE C 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M 8. DATE OF BIRTH 2-7-1901 9. AGE (In years last birthday) 49 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10B. KIND OF BUSINESS OR INDUSTRY 3 STROUT RD. S. C. 11. BIRTHPLACE (State or foreign country) S. C. 12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME Warren Wade 14. MOTHER'S MAIDEN NAME Mary ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 212-05-5736 17. INFORMANT Hattie Wade ADDRESS 622 Laurens St

18. 481 X I CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Empyema DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Influenza DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pleuritis (C) \_\_\_\_\_

19A. DATE OF OPERATION none 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from March 25, 1950, to March 28, 1950, that I last saw the deceased alive on March 26, 1950, and that death occurred at 5 A. M., from the causes and on the date stated above.

23A. SIGNATURE Hood Woolridge M. D. 23B. ADDRESS Elkridge Md 23C. DATE SIGNED 3/30 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/1/50 24C. NAME OF CEMETERY OR CREMATORY W. Auburn 24D. LOCATION (City, town, or county) (State) md

DATE RECEIVED BY LOCAL REGISTRAR MAR 30 1950 REGISTRAR'S SIGNATURE William M. ... 25. FUNERAL DIRECTOR Leslie Nelson ADDRESS 1303 Presa ...

VS 150 9844 33B



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully surveyed and legibly correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NORRIS  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2974

BIRTH NO. 50 2974

1. NAME OF DECEASED (Type or Print) <i>Georgiana Norris</i>		2. DATE OF DEATH <i>3/30/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence) A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Randallstown</i>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>Winans Rd</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m</i>	8. DATE OF BIRTH <i>11/20/1894</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Eugene Water</i>		14. MOTHER'S MAIDEN NAME <i>Grace Bruce</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Ralph Smith</i>		ADDRESS <i>15 #7 Fulton Ave</i>	

18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Intracerebral hemorrhage</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive cardiovascular disease</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *3/29*, 1950, to *3/30*, 1950, that I last saw the deceased alive on *3/30*, 1950, and that death occurred at *7 A. m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Red R. McClintock, Jr.</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>3/30/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/2/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St Thomas</i>	
24D. LOCATION (City, town, or county) (State) <i>Randallstown, Md</i>		25. FUNERAL DIRECTOR <i>W. H. Kelson</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 30 1950</i>		REGISTRAR'S SIGNATURE <i>W. H. Kelson</i>			

93D ST.



with

~~Robertson~~

William R.

11/20/1904

Th.

Home

H. W. R.

Cypress Water

Grace Cannon

Robertson 11/20/1904

11/20/1904  
Robertson, W.  
11/20/1904  
11/20/1904



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

152

50 2975

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2975

Registered No.

BIRTH NO.

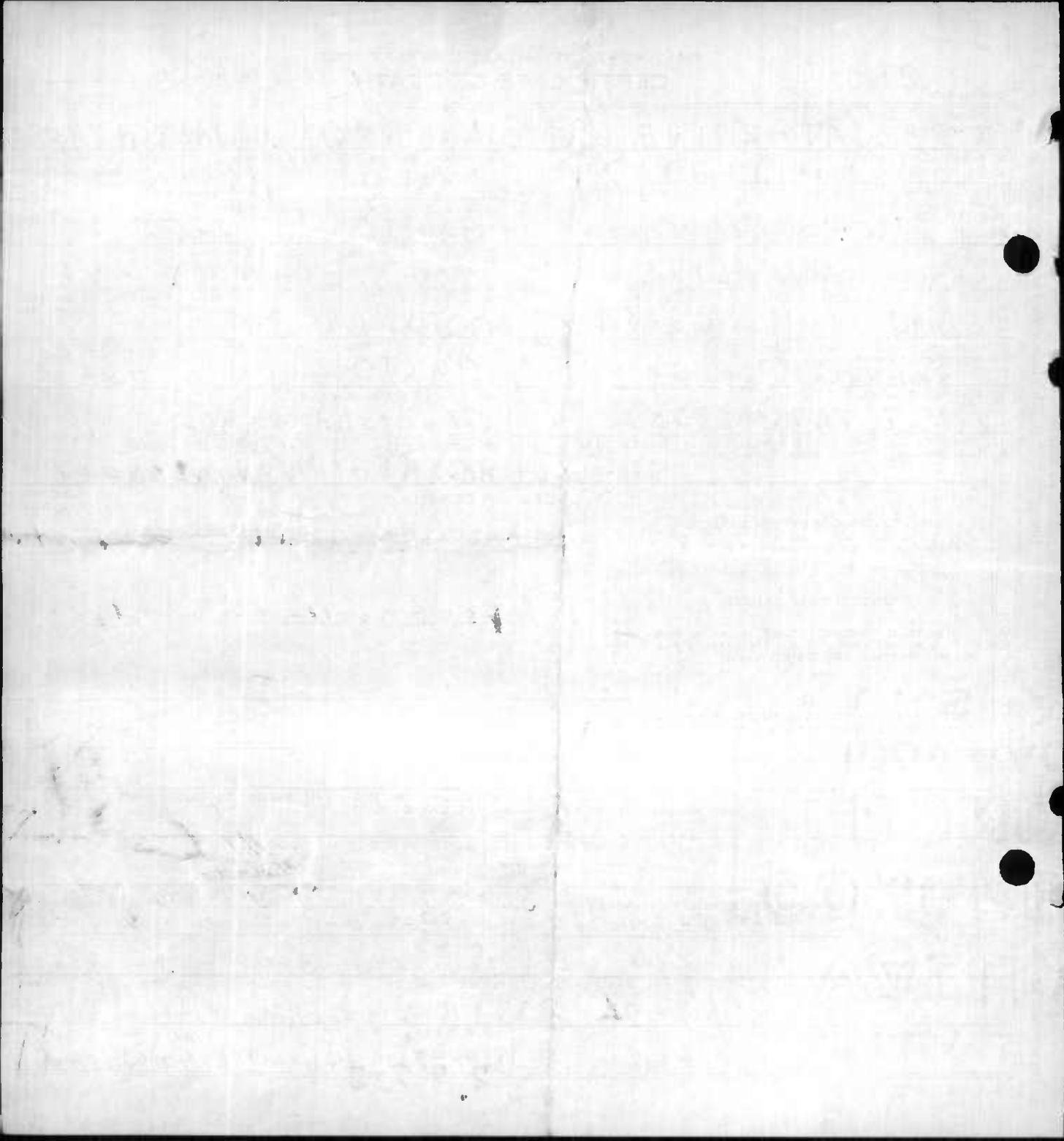
1. NAME OF DECEASED (Type or Print) CATHERINE (KATIE) LUBINSKI		2. DATE OF DEATH MARCH 29/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTO MD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1200 S. ELLWOOD AVE		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. 1-01	
c. Length of stay in Baltimore LIFE		D. STREET ADDRESS (If rural, give location) 1200 S. ELLWOOD AVE	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT 21 1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANNING		10B. KIND OF BUSINESS OR INDUSTRY PACKING	9. AGE (In years last birthday) 58
11. BIRTHPLACE (State or foreign country) BALTO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VINCENT MALCZEWSKI		14. MOTHER'S MAIDEN NAME STANISLAWA KROLBICKI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-3419	
17. INFORMANT MRS. REGINA ANGIOLONE		3208 1/2 GARDEN ST	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. MYOCARDITIS DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 yr.
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JUNE 2, 1949 to MARCH 29, 1950 that I last saw the deceased alive on MARCH 29, 1950, and that death occurred at 2:20 PM, from the causes and on the date stated above.			
23A. SIGNATURE Benjamin A. Hylkowsky		23B. ADDRESS 121 S. HILKOWSKI	
23C. DATE SIGNED 3/29/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE April 1/50	
24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		24D. LOCATION (City, town, or county) (State) GERMANTOWN ROAD	
25. FUNERAL DIRECTOR STEPHEN J. ZALOWSKI		1000 SKENESAW	
DATE RECEIVED BY LOCAL REGISTRAR MAR 30 1950		REGISTRAR'S SIGNATURE [Signature]	

VS 150

496X1

93E







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2976  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

STEPHEN L. GLEBA

2. DATE  
OF  
DEATH

March 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1924 E. 28th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1924 E. 28th Street

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

October 7, 1900

9. AGE (In years last birthday)

49

10. Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR INDUSTRY

Contractors (CONST)

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Gleba

14. MOTHER'S MAIDEN NAME

Josephine Golecki

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.  
216 01 2289

17. INFORMANT

ADDRESS

Mrs. Mary Gleba, 1924 E. 28th Street

MEDICAL CERTIFICATION

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Refooted appendix

3 mo.

5 years

6 mo.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb. 1946, to Mar 1950, that I last saw the deceased alive on Mar. 28, 1950, and that death occurred at 4:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Dr. M. J. Zimmelman

M. D.

23B. ADDRESS

2058 Harford Rd

23C. DATE SIGNED

29 Mar. 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, town or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

M. F. Sadowski & Sons, 1808 Eastern Avenue



STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CITY OF CLEVELAND  
OFFICE OF THE REGISTRAR  
1000 CLEVELAND SQUARE  
CLEVELAND, OHIO 44115

DATE

TIME

PLACE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

POLITICAL PARTY

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2977  
Registered No. \_\_\_\_\_

BIRTH NO. 2977

1. NAME OF DECEASED (Type or Print) <b>Norma Crockett</b>			2. DATE OF DEATH <b>3/29/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>27-10</b>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>605 Winston Ave.</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 20, 1877</b>		9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surf</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Balto.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Samuel M. Waggener</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Jane Kirby</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <b>157X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Pancreas</b> DUE TO <b>generalized carcinomatosis</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) DUE TO  (C) DUE TO		
19A. DATE OF OPERATION <b>2/25/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2/25/50</b> 19__, to <b>3/29/50</b> 19__, that I last saw the deceased alive on <b>3/29/50</b> 19__, and that death occurred at <b>8:30 p. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John P. Ramo</b>		23B. ADDRESS <b>Mary Prop.</b>		23C. DATE SIGNED <b>3/29/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 1-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>	REGISTRAR'S SIGNATURE <b>Edith...</b>	25. FUNERAL DIRECTOR <b>Wanda Hoffman</b>		ADDRESS <b>1639 Broadway</b>	

MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, IN UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

469



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

REPORT OF THE DEPARTMENT OF HEALTH  
ON THE RESULTS OF THE  
CENSUS OF 1900

ALBANY: J. B. LIPPINCOTT & CO.,  
1901.

THE DEPARTMENT OF HEALTH  
HAS THE HONOR TO ACKNOWLEDGE  
THE RECEIPT OF THE

REPORT OF THE DEPARTMENT OF HEALTH  
ON THE RESULTS OF THE  
CENSUS OF 1900

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ALBANY: J. B. LIPPINCOTT & CO.,  
1901.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2978

BIRTH NO. 50 2978

1. NAME OF DECEASED (Type or Print) <b>(SADIE BELLE STEWART)</b>		2. DATE OF DEATH <b>3/28/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital Don</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - 4</b>	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>6601 Lockhill Rd.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	B. DATE OF BIRTH <b>Dec. 3. 1889</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher, Baltimore</b>			9. AGE (In years last birthday) <b>60</b> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
13. FATHER'S NAME <b>John Chew Stewart</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			14. MOTHER'S MAIDEN NAME <b>Mildred Eliza Wright</b>
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Mrs. Charles Feldhaus</b>
			ADDRESS <b>Gaithersburg Md.</b>
18. <b>420.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b> (A) ..... DUE TO ANTECEDENT CAUSES (B) ..... DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. (C) ..... II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <b>William G. Helrich</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	
23C. DATE SIGNED <b>3/28/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 1. 1950</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>		REGISTRAR'S SIGNATURE <b>Henry Sander &amp; Sons, Inc.</b>	
25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>		ADDRESS <b>North &amp; Broadway. Baltimore.</b>	

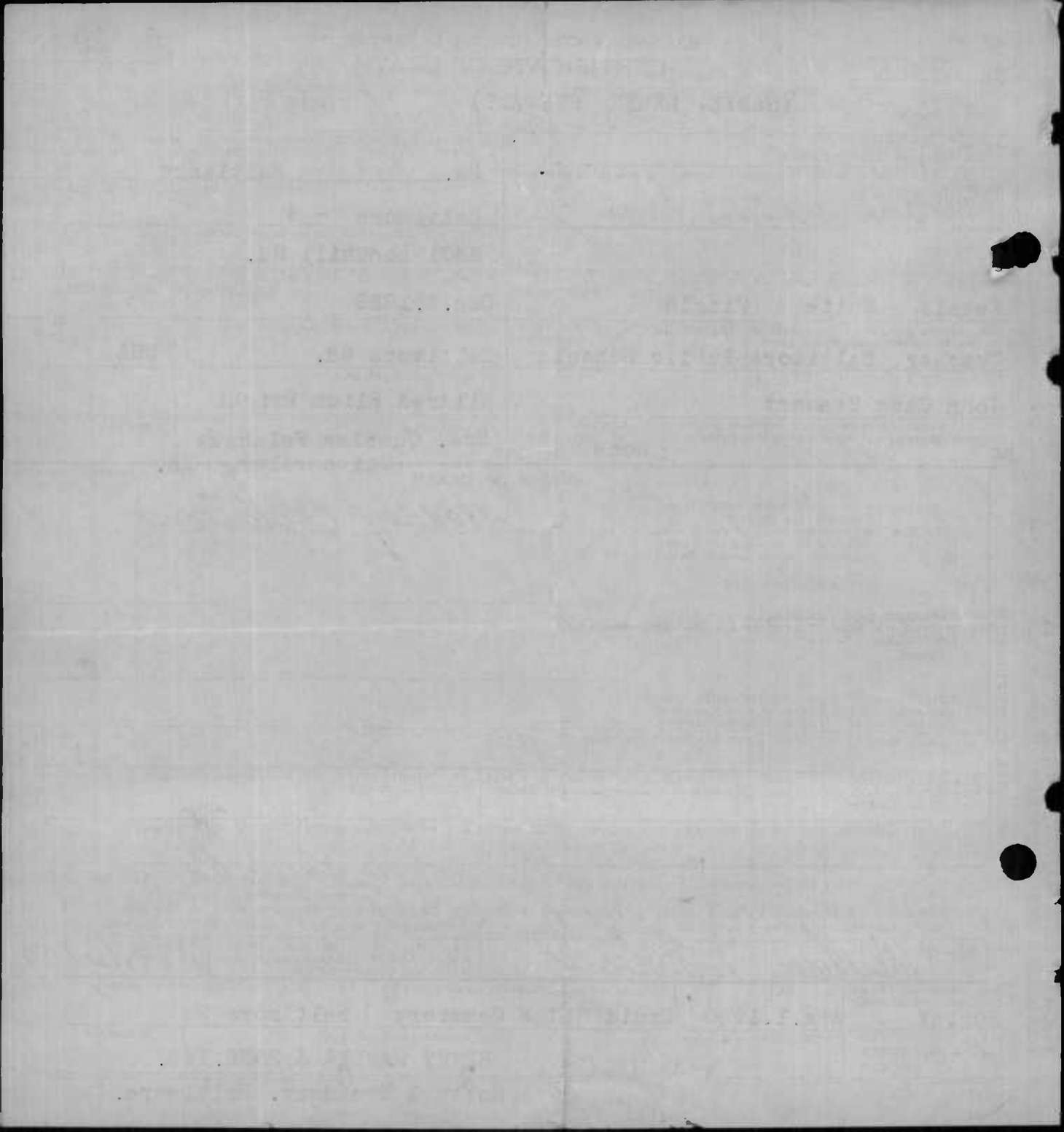
VS 151

V3491

North & Broadway. Baltimore.

94a







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 2979

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) **ALFRED****HEATH****(ALFRED EUGENE HEATH)**2. DATE  
OF DEATH **March 28, 1950**

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION**Maryland General Hospital**Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

O. STREET ADDRESS (If rural, give location)

**718 W. North Avenue**

5. SEX

**male**

6. COLOR OR RACE

**white**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
**married**

8. DATE OF BIRTH

**Aug. 24, 1912**9. AGE (In years  
last birthday)**37**10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**CAB DRIVER**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Baltimore Md.**12. CITIZEN OF  
COUNTRY?**USA**

13. FATHER'S NAME

**Richard R. Heath**

14. MOTHER'S MAIDEN NAME

**Margaret E. Jones**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL SECURITY NO.  
**213-05-7732**17. INFORMANT **Mrs. Richard R. Heath (Mother)**  
**2877 Chesterfield Ave.**18. **E97v**

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

**Carbon monoxide poisoning**

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)  
**home**21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?**718 W. North Avenue**21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY**March 28, 1950 ? m.**

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Four burners and oven open but unlit**22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Dr. J. Mc Clafferty**23B. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

**March 29, 1950**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)**Burial**

24B. DATE

**Mar. 31, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Baltimore Cemetery**

24D. LOCATION (City, town, or county)

**Baltimore Md.**DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Henry Sander & Sons, Inc.**

25. FUNERAL DIRECTOR

**HENRY SANDER & SONS, INC.**

ADDRESS

VS 151

**N-968****4205V****Baltimore Md.****163H**



CENTRAL BANK OF DENMARK

THE BANK OF DENMARK

DATE	1914
NO.	1000
AMOUNT	1000
CURRENCY	DANISH CROWN
ISSUED BY	CENTRAL BANK OF DENMARK
SIGNED	
SEAL	

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correct age is especially important. Physicians please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2980  
Registered No. 50 2980

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LENA ELIZABETH COLLIER

2. DATE  
OF DEATH Mar. 27. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

3111 Clifftmont Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore -13

8-01

D. STREET ADDRESS (If rural, give location)

3111 Clifftmont Ave.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

- - -

13. FATHER'S NAME

Joseph Panuska

8. DATE OF BIRTH

July 19. 1904

9. AGE (In years last birthday)

45 46

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Kunigunda Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT 3111 Clifftmont Ave.  
Charles A. Collier (Husband)

18. 422.2

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

5-10-49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatoid Arthritis

1940

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6-1-, 1944 to 3-27-, 1950, that I last saw the deceased alive on 3-27-, 1950, and that death occurred at 8 p m., from the causes and on the date stated above.

23A. SIGNATURE

Walter C. Lang

M. D.

23B. ADDRESS

2117 Belair Rd

23C. DATE SIGNED

3-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 31. 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 30 1950

REGISTRAR'S SIGNATURE

Walter C. Lang

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

ADDRESS

Baltimore Md.

93c



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VALLEY

WISCONSIN

CHICAGO

LIBRARY

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

460

50 2981

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2981

Registered No.

BIRTH NO.

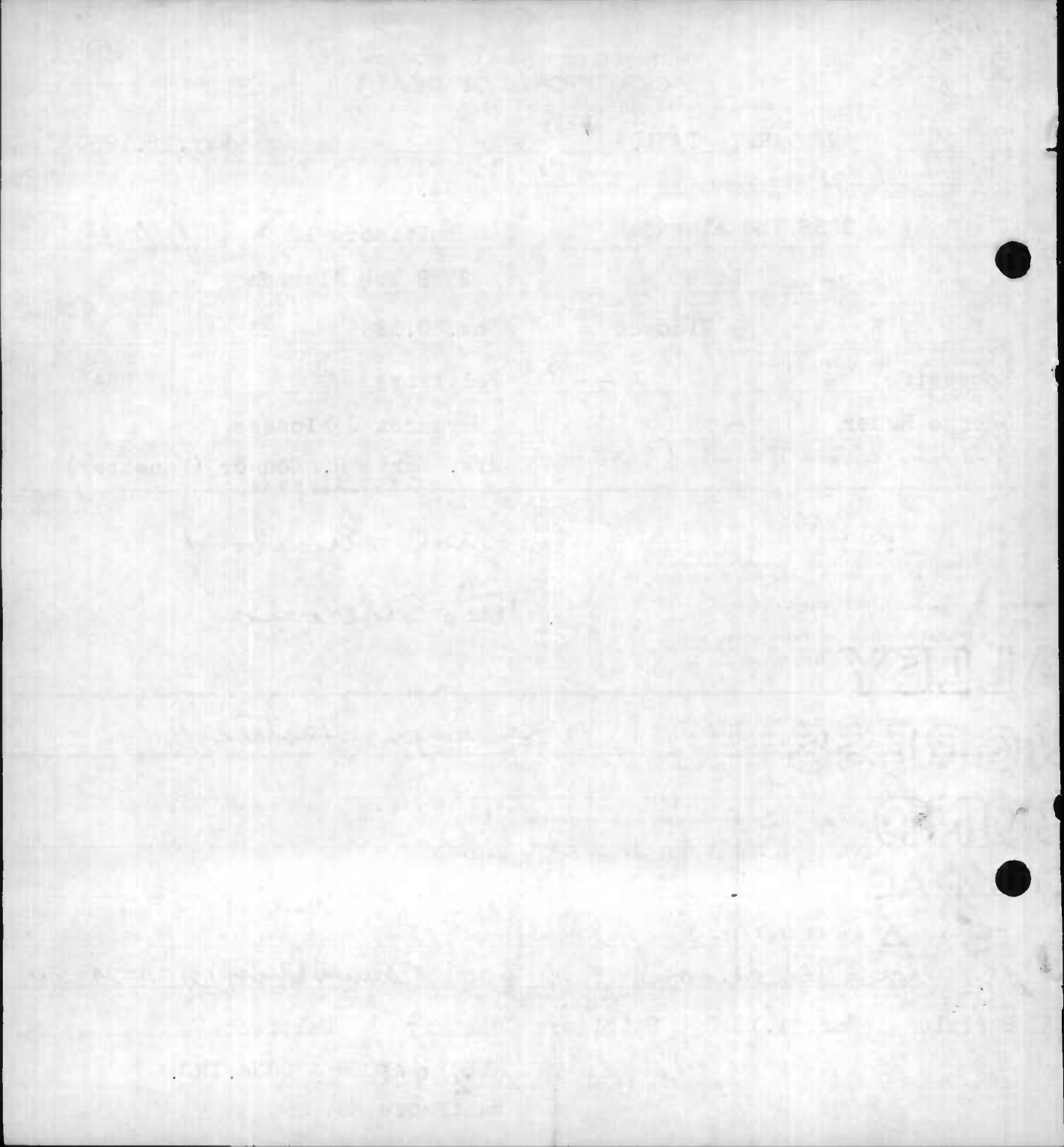
1. NAME OF DECEASED (Type or Print) <b>MARGARET TAYLOR</b>			2. DATE OF DEATH <b>Mar. 28, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2738 The Alameda</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 18</b>		
D. STREET ADDRESS (If rural, give location) <b>2738 The Alameda</b>			E. LENGTH OF STAY IN BALTIMORE <b>Life</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 30, 1866</b>		9. AGE (In years last birthday) <b>83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Roder</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Schlosser</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>(Yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Marie H. Conner (Daughter) 2738 Alameda</b>		

18. <b>332X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>			CAUSE OF DEATH <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arterio-Sclerosis</b>			(B) <b>Arterio-Sclerosis</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma (Gastric)</b>			(C) <b>Carcinoma (Gastric)</b>					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>Aug</b> , 19 <b>49</b> , to <b>March 28</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>March 28, 1950</b> and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above.								
23A. SIGNATURE <b>Charles A. Anderson</b>		23B. ADDRESS <b>3001 Shannon Drive (13)</b>		23C. DATE SIGNED <b>3-29-50</b>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar. 31, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>				

VS 150

46B







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2982

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>EMMA MARIE FREDERICK</b> <i>Miss Emma Marie Frederick</i>			2. DATE OF DEATH <b>3-29-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>The Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 24 1-02</b>		
D. STREET ADDRESS (If rural, give location) <b>229 So. Ellwood ave</b>			5. LENGTH OF STAY IN BALTIMORE <b>Life</b>		
5. SEX <b>FG</b>	6. COLOR OR RACE <b>W</b>	7. <del>SINGLE</del> MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Sept 3, 1895</b>		9. AGE (In years last birthday) <b>54</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>art instructor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Pub. Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>George John Frederick</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Marie Meister</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT ADDRESS <b>Mrs. George Sturmfels (sister) 1208 Southview Road, -18</b>		

18. <b>193X</b>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Brain Tumor (Glioma)</b>						<b>app. 1 mo.</b>		
ANTECEDENT CAUSES								
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pneumonia (terminal)</b>								
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION <b>3-21-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>advanced stage of glioma in brain</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>Mar. 19</b> , 1950, to <b>Mar. 29</b> , 1950, that I last saw the deceased alive on <b>Mar 29</b> , 1950, and that death occurred at <b>6:47 Pm.</b> , from the causes and on the date stated above.								
23A. SIGNATURE <b>Francis Russell Watt</b>			23B. ADDRESS <b>M. O. Union Memorial Hosp.</b>			23C. DATE SIGNED <b>Mar 29 1950</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 1, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>		REGISTRAR'S SIGNATURE <i>William J. Williams</i>		25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC</b>		ADDRESS <b>Baltimore Md.</b>		

Physicians: please write the causes of death clearly and legibly. correct age is especially important.



CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH



correct age is especially important. Physicians write the causes of death clearly and legibly.

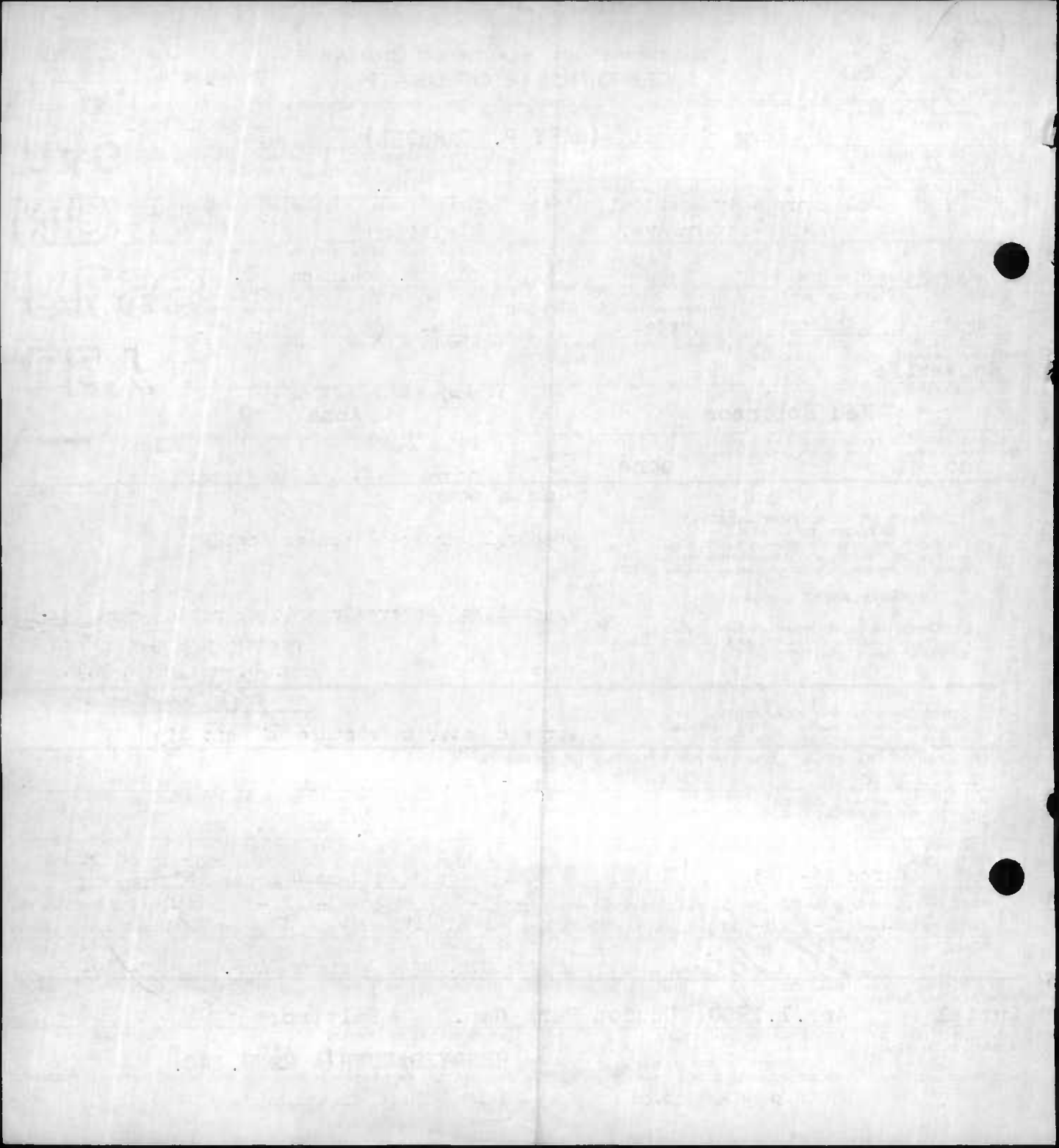
BALTIMORE CITY HEALTH DEPARTMENT				50 2983		Registered No.	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)				Mary Carroll (MARY P. CARROLL)		2. DATE OF DEATH 3- 28- 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-02			
Length of stay in Baltimore Life				D. STREET ADDRESS (If rural, give location) 610 S. Robinson ST.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	B. DATE OF BIRTH May 6- 1868		9. AGE (In years last birthday) 81 Yrs.	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME (D) Ned Robinson				14. MOTHER'S MAIDEN NAME (D) Anna ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Records B.C.H. 4940 Eastern Ave.		ADDRESS	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Cardio- Vascular Accident DUE TO ANTECEDENT CAUSES Generalized Severe Arteriosclerotic Heart Disease DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Intertrochanteric Fracture of Left Hip II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH CERTIFICATION APPROVED BY Wm. G. Helfrich, M.D. R. S. Fisher, M.D. CHIEF OR ASST. MEDICAL EXAMINER.			
19A. DATE OF OPERATION 3- 28- 1950		19B. MAJOR FINDINGS OF OPERATION Hip Fracture - Ins. Blount Plate		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 610 S. Robinson St.			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY March 25- 1950 m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Just slumped to the floor Admitted Fell At home 4 Hours Before Being			
22. I hereby certify that I attended the deceased from 3- 25- 1950, to 3- 28- 1950, that I last saw the deceased alive on 3- 28- 1950, and that death occurred at 6.44PM m., from the causes and on the date stated above.							
23A. SIGNATURE H. C. Boyer		23B. ADDRESS B.C.H. 4940 Eastern Ave.		23C. DATE SIGNED 3- 29- 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 1. 1950		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR MAR 30 1950		REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.		ADDRESS	

VS 150

To Be Approved By The Chief Medical Examiner.

93D







423

JL-91523  
50 2984BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2984

1. NAME OF DECEASED (Type or Print) <b>Mary Halstead</b>			2. DATE OF DEATH <b>3-29-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>2-03</b>		
D. STREET ADDRESS (If rural, give location) <b>1927 Eastern Ave.</b>			E. Length of stay in Baltimore <b>13 yrs.</b> Yrs. <b>13</b> Mos. <b>0</b> Days <b>0</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>Aug. 17, 1882</b>	9. AGE (in years last birthday) <b>67</b>	10. Under 1 Year Months: <b>0</b> Days: <b>0</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Joseph Williams</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Jenkins</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave.</b>			ADDRESS		

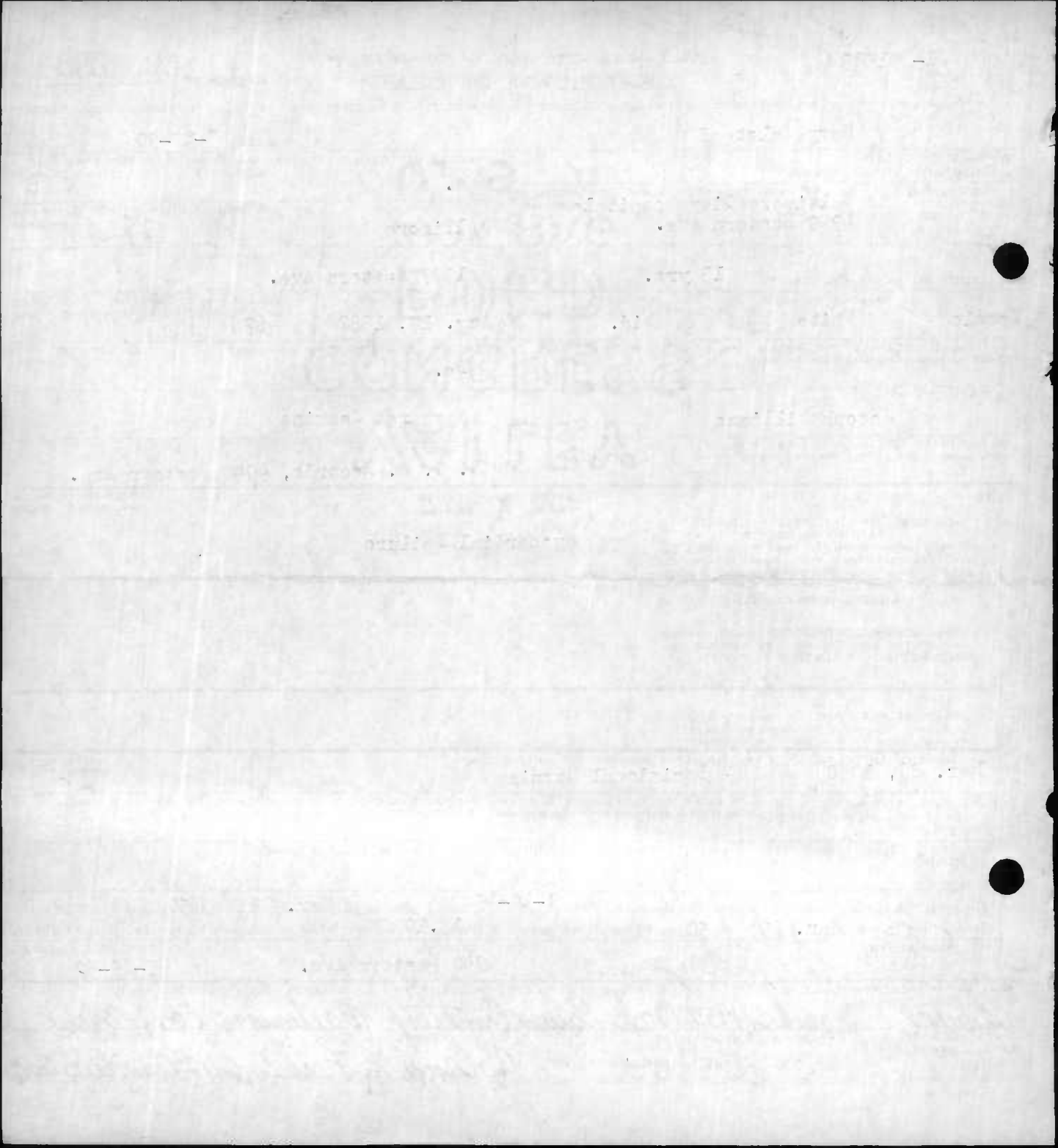
18. <b>5603</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Failure</b> (A) <b>Myocardial Failure</b> DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>Mar. 28, 1950</b>	19B. MAJOR FINDINGS OF OPERATION <b>Incisional Hernia</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>1-10-45</b> , 19 <b>45</b> , to <b>Mar. 29</b> , 1950, that I last saw the deceased alive on <b>Mar. 29</b> , 19 <b>50</b> , and that death occurred at <b>12.10 AM</b> from the causes and on the date stated above.		
23A. SIGNATURE <b>J. B. Oger</b> M. D.	23B. ADDRESS <b>4940 Eastern Ave.</b>	23C. DATE SIGNED <b>3-29-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>March 31, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 30 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington H. Jones</b>	25. FUNERAL DIRECTOR <b>Poland L. Fisher</b>	ADDRESS <b>2112 Dundalk Ave.</b>

correct age is especially important. Physicians: please write the causes of death clearly and legibly.







correct age is permanently important. Physicians write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2985

Registered No. \_\_\_\_\_

50 2985

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Mary Oakley*

2. DATE  
OF  
DEATH

*March 24/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *md.* B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*1703 Brentwood Ave.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 12-05*

D. STREET ADDRESS (If rural, give location)

*1703 Brentwood Ave*

E. Length of stay in Baltimore

*Life*

Yrs.  
Mos.  
Days

5. SEX

*7*

6. COLOR OR RACE

*Co*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Widow*

8. DATE OF BIRTH

*March 8, 1880*

9. AGE (in years last birthday)

*70*

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*md.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*unknown*

14. MOTHER'S MAIDEN NAME

*unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
*Lamanda Blunt 610 N. Bonds*

18. *592 X*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Chronic Nephritis*

*3 mos*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Myocardial Degeneration*

*2 mos*

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Sept. 23*, 1949 to *Mar. 24*, 1950, that I last saw the deceased alive on *Mar. 24*, 1950, and that death occurred at *6:00 p. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Franklin Phillips*

23B. ADDRESS

*1543 Penma Ave.*

23C. DATE SIGNED

*3/28/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 31/50*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Calvary Cem.*

24D. LOCATION (City, town, or county)

*29. County md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

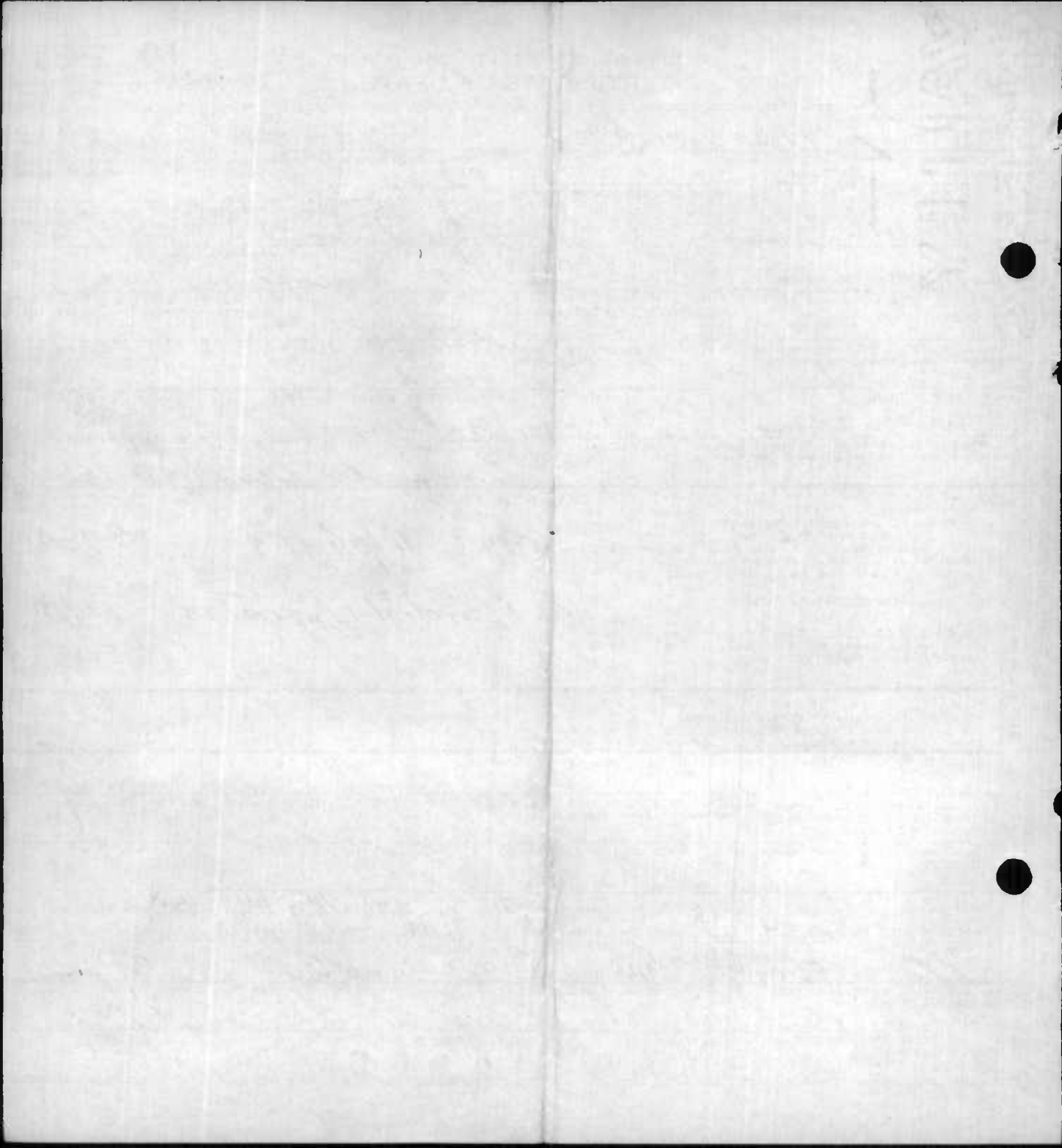
*Wm. H. Williams, Jr.*

25. FUNERAL DIRECTOR

*Wm. C. G. Elliott & Son*

ADDRESS







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2986

Registered No. \_\_\_\_\_

50 2986

1. NAME OF DECEASED  
(Type or Print)

**FANNIE BODIEN BYERS**

2. DATE OF DEATH  
**Mar. 30, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**3432 Piedmont Ave.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore** **15-08A**

D. STREET ADDRESS (If rural, give location)  
**3432 Piedmont Ave.**

E. Length of stay in Baltimore

5. SEX **female** 6. COLOR OR RACE **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **widow**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife** 10B. KIND OF BUSINESS OR INDUSTRY **at home**

13. FATHER'S NAME

**Henry A. Bodien**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
**no**

16. SOCIAL SECURITY NO.  
**no**

8. DATE OF BIRTH **Oct. 5, 1859** 9. AGE (In years last birthday) **90**

11. BIRTHPLACE (State or foreign country) **Washington, D. C.** 12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

14. MOTHER'S MAIDEN NAME

**Eliza Hogg**

17. INFORMANT ADDRESS  
**Miss Fannie B. Byers 3432 Piedmont Ave.**

18. **450.0**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cardiac decompensation**

DUE TO

**1 day**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **General Arterio Sclerosis**

DUE TO

**10 yrs**

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept 1**, 19**49**, to **March 30**, 19**50**, that I last saw the deceased alive on **March 30**, 19**50**, and that death occurred at **5A** m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

**Burial**

**4/1/50**

**Loudon Park Cem.**

**Balto., Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**MAR 30 1950**

**Wm J. Tiekner & Sons**

**Balto., Md.**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

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PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE



B-400

50 2987

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2987

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Agnes Bailey

2. DATE  
OF  
DEATH

MAR 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Phillip Monney

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 463X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Pulmonary Embolus

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Phlebothrombosis Left Leg

(B)

Carcinoma of Stomach

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

0

1 day

6 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-14, 1950, to 3-28, 1950, that I last saw the deceased alive on 3-28, 1950, and that death occurred at 7:10 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert P. Donnell

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-31-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Frances A. Hemsley 778 W. Biddle St.

VS 150

46B

My important. Physicians: please write the causes of death clearly and legibly.  
correct age is especially important.

MEDICAL CERTIFICATION



UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

*John Smith*

*Male*

*White*

*1111 1st Street*

*City, State*

*Age*

*Occupation*

*Married*

*Single*

*Widowed*

*Divorced*

*Never married*

*Married*

*Single*

*Widowed*

*Divorced*

*Never married*

*Married*

*Single*

*Widowed*

*Divorced*

*Never married*

*Married*

*Single*

*Widowed*

*Divorced*

*Never married*

*Married*

*Single*

*Widowed*

*Divorced*

*Never married*

*John Smith*

*John Smith*

*John Smith*

*John Smith*

*John Smith*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2988  
Registered No. \_\_\_\_\_

BIRTH NO. 50 2988

1. NAME OF DECEASED (Type or Print) <b>John Thomas Powell</b>			2. DATE OF DEATH <b>March 29, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>890 Linden Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>890 Linden Ave.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>May 6, 1891</b>	9. AGE (In years, last birthday) <b>58</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steward</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Navy- Ret.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>
13. FATHER'S NAME <b>John T. Powell</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Iler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-28-4694</b>	17. INFORMANT <b>Mrs Bernice Hawkins</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-28-4694</b>	ADDRESS <b>890 Linden Av.</b>		

18. <b>CAUSE OF DEATH</b>				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Carcinoma of Stomach</b>				<b>6 mrs</b>	
DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Myocardial Failure</b>				<b>unk</b>	
DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C)</b>					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept. 28, 1949</b> to <b>March 29, 1950</b> , that I last saw the deceased alive on <b>3/17, 1950</b> , and that death occurred at <b>5:10 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Franklin D. Phelps</b>		23B. ADDRESS <b>1543 Penna Ave</b>		23C. DATE SIGNED <b>3/30/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 1, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Quarter Bottom</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>E. W. Williams</b>	25. FUNERAL DIRECTOR <b>Mrs. Frances A. Hemsley</b>		ADDRESS <b>573 W. Biddle St.</b>	

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



RECEIVED BY THE DIRECTOR  
OF THE BUREAU OF THE  
CUSTOMS AND EXCISE

1918

ON JAN 12 1918

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 2989**

BIRTH NO. **50 2989**

1. NAME OF DECEASED  
(Type or Print)

*John Benedict*

2. DATE  
OF  
DEATH

*Mar. 28/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Balto Md*

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*Balto. Md.*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*5922 Bertram Ave*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*June 10, 1868*

9. AGE (In years,  
last birthday)

*81*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Carpenter*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Bldg. Carpenter*

11. BIRTHPLACE (State or foreign country)

*Bohemia*

12. CITIZEN OF  
WHAT COUNTRY?

*U. S. A*

13. FATHER'S NAME

*Frank Benedict*

14. MOTHER'S MAIDEN NAME

*Josephine Kulanch*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

*On one*

17. INFORMANT

ADDRESS

*Beatrice Benedict 5922 Bertram Ave*

18. *450.0*

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) .....

*Arteriosclerosis, generalized*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) .....

DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

*Contusion, left chest*

*1 wk*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

*In Home*

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

*5922 Bertram Ave - Balto. Md*

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

*March 18 1950 7P*

21E. INJURY OCCURRED

WHILE AT ☐ WORK NOT WHILE ☒ AT WORK

21F. HOW DID INJURY OCCUR?

*While walking, fell against table*

22. I hereby certify that I attended the deceased from *March 20, 1950* to *March 28, 1950* that I last saw the  
deceased alive on *March 27, 1950* and that death occurred at *8:30* a.m., from the causes and on the date stated above.

23A. SIGNATURE

*Charles P. Sevier*

M. D.

23B. ADDRESS

*4700 Parkwood Ave*

23C. DATE SIGNED

*3/29/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*March 31/50*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer*

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

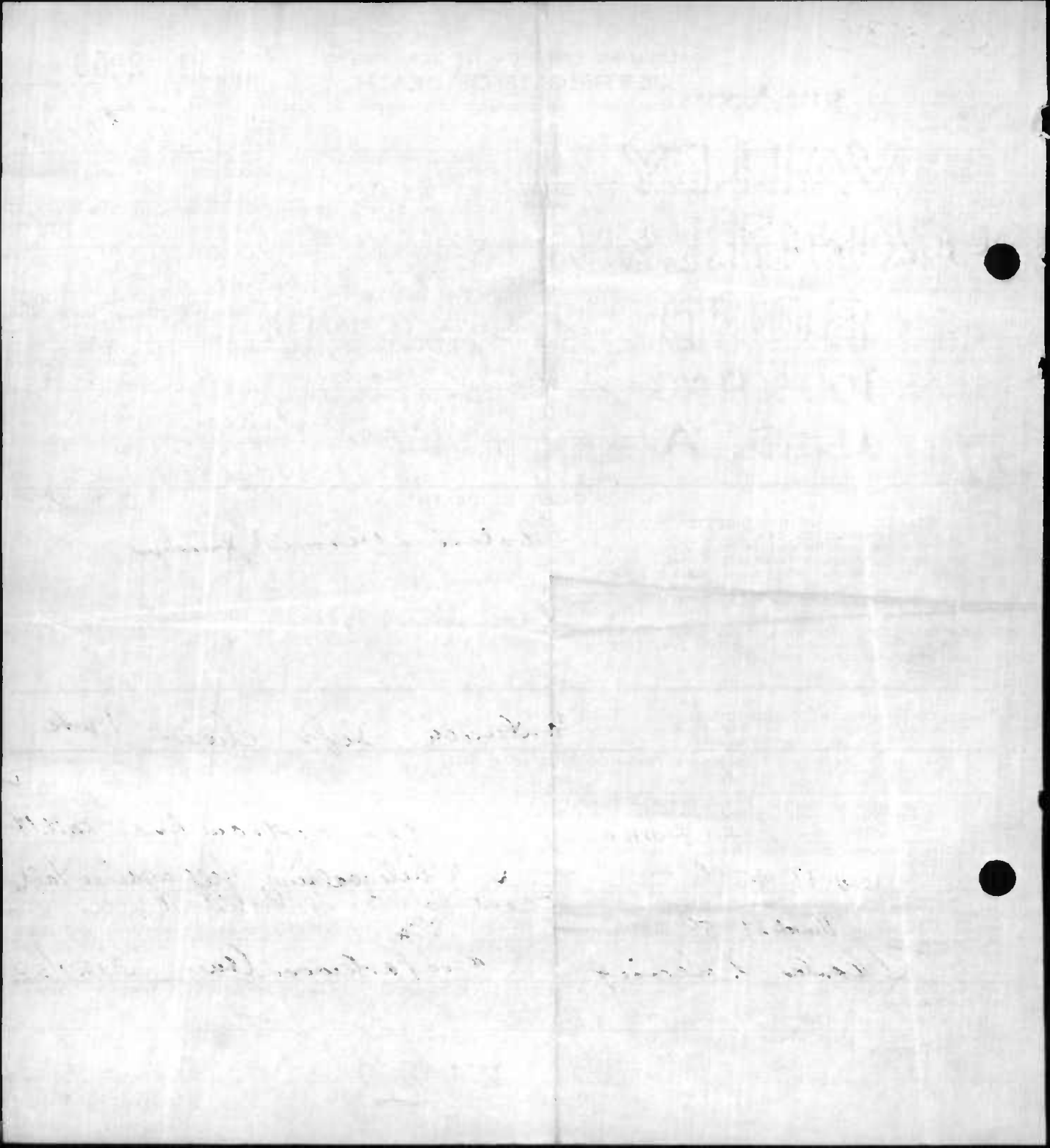
ADDRESS

*Wm. H. Sullivan 8000 Chester*

VS 150

97







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 2990  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**BERNARD DIXON**

2. DATE  
OF  
DEATH

**3-30-50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

**UNIVERSITY HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MD.** B. COUNTY **Prince George**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**LAUREL** **6637**

C. Length of stay in Baltimore

**2**  
Days

D. STREET ADDRESS (If rural, give location)  
**606 MAIN STREET**

5. SEX

**M**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**MARRIED**

8. DATE OF BIRTH

**1887**

9. AGE (In years last birthday)

**63**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**CARMAN**

10B. KIND OF BUSINESS OR INDUSTRY

**STEEL ROLLER**

11. BIRTHPLACE (State or foreign country)

**MO.**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**WILLIAM DIXON**

14. MOTHER'S MAIDEN NAME

**MARY BAKEMAN**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**UNKNOWN**

16. SOCIAL SECURITY NO.

**SELF**

18. **154X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **CEREBRO-VASCULAR ACCIDENT?**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **HYPERTENSIVE C.V. DISEASE**

DUE TO

**OR**

(C) **CEREBRAL METASTASES FROM**

**CA RECTUM**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**CA RECTUM - INTESTINAL OBSTRUCTION**

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-29**, 19**50**, to **3-30**, 19**50**, that I last saw the deceased alive on **3-30**, 19**50** and that death occurred at **3:40** P.m., from the causes and on the date stated above.

23A. SIGNATURE

**J. J. Phelan**

M. D.

23B. ADDRESS

**University Hospital**

23C. DATE SIGNED

**3-30-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

**April 1, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Meadowridge Mem. Park**

24D. LOCATION (City, town, or county)

**Dorsey, Md**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**MAR 31 1950**

REGISTRAR'S SIGNATURE

**W. J. Phelan**

25. FUNERAL DIRECTOR

**W. J. Phelan**

ADDRESS

**W. J. Phelan**

correct age is especially important. Physicians write the causes of death clearly and legibly.







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 2991 Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas F. Whitson

2. DATE  
OF  
DEATH

Mar 30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2020 Greenberry Road

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore (Mt. Washington)

D. STREET ADDRESS (If rural, give location)

2020 Greenberry Road

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

June 18, 1870

9. AGE (In years last birthday)

79

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Marine Consulting Eng.

10B. KIND OF BUSINESS OR INDUSTRY  
(retired) Self

11. BIRTHPLACE (State or foreign country)

Lima Peru

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Archibald H. Whitson

14. MOTHER'S MAIDEN NAME

Matilda Casanave

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

22-18-8512A

17. INFORMANT

ADDRESS

Rd.

Mrs. Hannah E. Whitson 2020 Greenberry

18. 157X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Generalized Carcinomatosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma of pancreas?

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

?

?

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Mar, 1950, to 30 Mar, 1950, that I last saw the deceased alive on 29 Mar, 1950, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

A. Allan Spier

M. D.

23B. ADDRESS

1134 C. Belvedere Ave

23C. DATE SIGNED

30 Mar 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

April 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

DRUID RIDGE CEMETERY

24D. LOCATION (City, town, or county)

PIKESVILLE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

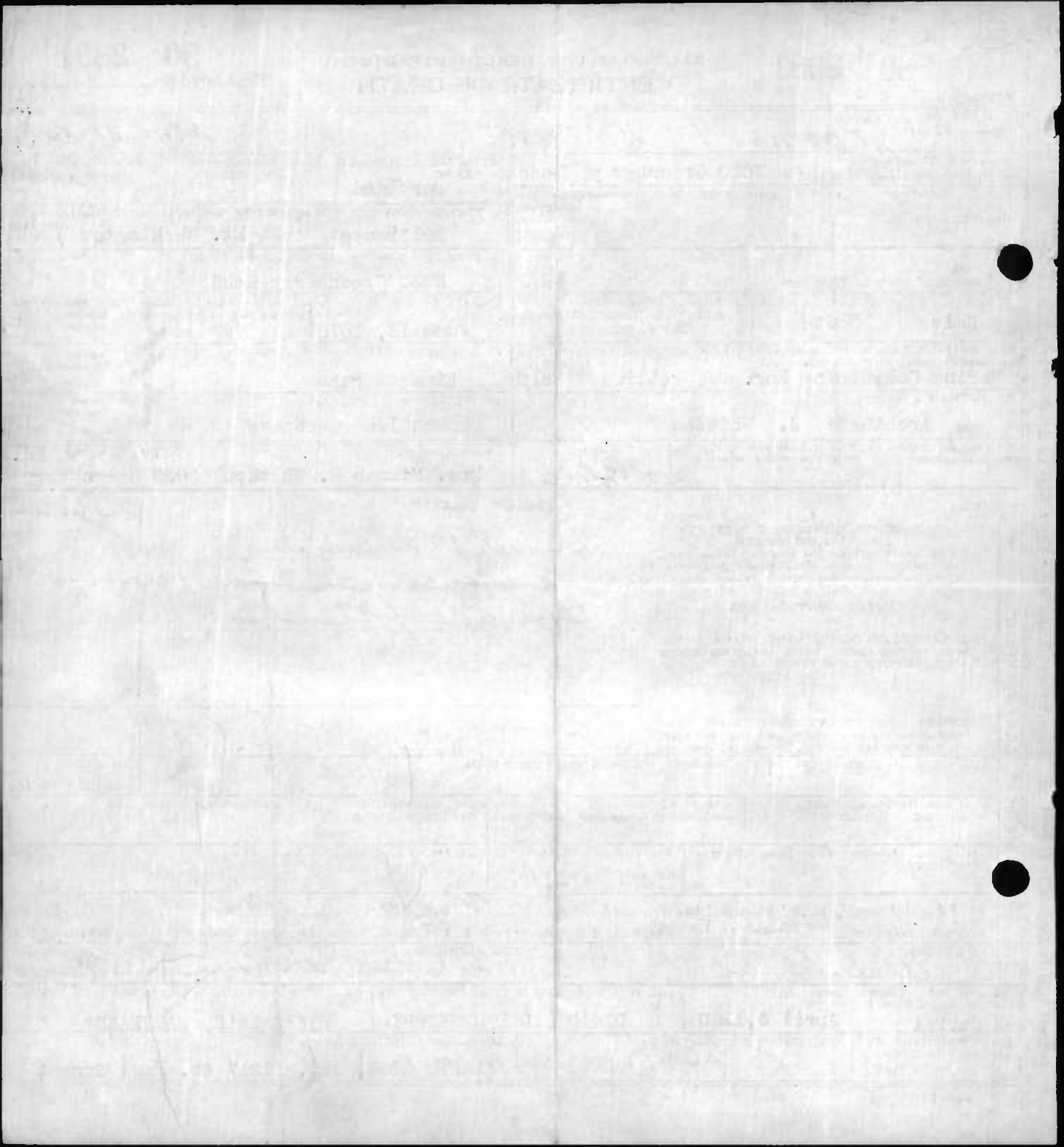
WOLLIAM COOK INC. 1217 St. Paul Street

MAR 31 1950

A. ALLAN SPIER

46g







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 2992**

BIRTH NO. **50-05217**

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Wodarski</b>			2. DATE OF DEATH <b>Mar. 14, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 2-02</b>		
C. Length of stay in Baltimore <b>1 day.</b>			D. STREET ADDRESS (If rural, give location) <b>1725 Gough St. # 31</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>	8. DATE OF BIRTH <b>Mar. 13, 1950</b>	9. AGE (In years last birthday) <b>1</b>	10. Under 1 Year Months: Days: <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Stanley Richard Wodarski, Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Anna Victoria Jeromin</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Anna Victoria Wodarski 1725 Gough St # 31</b>		

18. <b>760.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Prematurity (Immaturity)</b>	CAUSE OF DEATH (A) <b>Prematurity (Immaturity)</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH
19. <b>II</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hemorrhage into Falcx Cerebri</b>	(B) <b>Hemorrhage into Falcx Cerebri</b> DUE TO	
20. <b>Interstitital Pulmonary Emphysema</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <b>Interstitital Pulmonary Emphysema</b>	

19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-13**, 19**44**, to **3-14**, 19**50**, that I last saw the deceased alive on **3-14**, 19**50**, and that death occurred at **3:40** a.m., from the causes and on the date stated above.

23A. SIGNATURE <b>Raymond B. Hildeberg</b>	23B. ADDRESS <b>803 Cathedral Rd.</b>	23C. DATE SIGNED <b>3-14-50</b>
---	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
---	-----------	------------------------------------	---

DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 31 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL HOME <b>2</b>	ADDRESS
--	---	------------------------------	---------



UNITED STATES OF AMERICA  
DEPARTMENT OF STATE

NEW YORK, N. Y.

April 1941

RECEIVED BY THE DEPARTMENT OF STATE

IN THE OFFICE OF THE SECRETARY OF STATE

(S)

RECEIVED  
APR 19 1941



correct age is especially important. Physicians write the causes of death clearly and legibly.

<div style="display: flex; justify-content: space-between;"> <span>163</span> <span>50 2993</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>50 2993</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>Registered No. _____</span> </div>	
BIRTH NO. <u>50-06572</u>	
1. NAME OF DECEASED (Type or Print) <u>Stephen William Ruppert.</u>	
2. DATE OF DEATH <u>3/24/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-47</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hosp. For Women of Md.</u>	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore-16</u>	
D. STREET ADDRESS (If rural, give location) <u>2954 Clifton Ave.</u>	
E. LENGTH OF STAY IN BALTIMORE <u>1 1/2</u> <small>Yrs. Mos. Days</small>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 22, 1950</u>
9. AGE (In years last birthday) <u>newborn</u>	10. BIRTHPLACE (State or foreign country) <u>Maryland</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>Frank William Ruppert, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Janet Julia Vancay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS	
18. <u>751</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
CAUSE OF DEATH	
(A) <u>Probable meningitis</u>	
DUE TO	
(B) <u>Spina Bifida &amp; Myelomeningocele &amp; hydrocephaly</u>	
DUE TO	
(C) _____	
INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 22, 1950</u> to <u>Mar. 24, 1950</u> that I last saw the deceased alive on <u>Mar. 24, 1950</u> , and that death occurred at <u>2 1/2</u> m., from the causes and on the date stated above.	
23A. SIGNATURE <u>William H. Spencer, Jr.</u> M. D.	23B. ADDRESS <u>Hosp. for Women of Md.</u>
23C. DATE SIGNED <u>3-28-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE
24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
JOHN HOPKINS MEDICAL SCHOOL MAR 30 1950 REGISTRAR'S SIGNATURE <u>Thurston Williams, Jr.</u> DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 31 1950</u> 25. FUNERAL DIRECTOR <u>Commissioner of Health</u> ADDRESS _____	







50 2994

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2994

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROSE EPSTEIN

2. DATE  
OF  
DEATH

3/31/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Sinai Hospital

C. Length of stay in Baltimore

43 Yrs

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 21, 1885

9. AGE (In years  
last birthday)

64

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife Own Home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank Greenberg

14. MOTHER'S MAIDEN NAME

Yetta ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Morris Epstein

ADDRESS

2024 E Baltimore St

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebrovascular accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive cardio-vas-  
cular disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/21, 1950, to 3/31, 1950, that I last saw the  
deceased alive on 3/31, 1950, and that death occurred at 3:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

William Kraker, M. D.

23B. ADDRESS

Sinai Hosp.

23C. DATE SIGNED

3/31/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

March 31, 1950

24C. NAME OF CEMETERY OR CREMATORY

Southern Ave Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Kraker, M. D.

25. FUNERAL DIRECTOR

ADDRESS

Sol Levinson &amp; Bros 1126 W North Ave



CERTIFICATE OF DEATH

3/21/50

ROSE E. STONE

Age 78

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years

Married 54 years



50 2995

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 2995

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary L. Blottenberger

2. DATE  
OF  
DEATH

Wed. March 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1714 Honover St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 470.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Crown Aneurysm

Minutes

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Smile Remission

15 yrs

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 3/18, 1950, to 3/29, 1950, that I last saw the  
deceased alive on 3/23, 1950, and that death occurred at A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 31 1950

Burial  
Mar. 1, 1950  
Benton Hill Cem.  
A. A. Co., Md.  
R. A. Evans  
1400 S. Charles St. Balto. 30, Md.



CERTIFICATE OF DEATH

THE STATE OF NEW YORK



1-460  
50 2996BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2996  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Michael A. Mueller

2. DATE  
OF  
DEATH

3-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Bon Secours Hosp

C. Length of stay in Baltimore

71 Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Chairman of Board - Dryola Bldg. Assoc.

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Adam Mueller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

2-1-79

9. AGE (In years,  
last birthday)

71

If Under 1 Year  
Months: Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Mary Koell

17. INFORMANT

ADDRESS

Mrs. Agnes B. Mueller 803 E. Belvedere Ave.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) CEREBRO-VASCULAR Hemorrhage

3-29-50

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROTIC Hypertension

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/29/1950, to 3/29/1950, that I last saw the  
deceased alive on 3/29/1950, and that death occurred at 2:50 Pm., from the causes and on the date stated above.

23A. SIGNATURE

D. J. Shrohler

23B. ADDRESS

M. D.

Bon Secours Hosp.

23C. DATE SIGNED

3/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/1/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

No. 25, 805 N. Calvert St.



CERTIFICATE OF DEATH

PLAZA DE LA VILLA



MS--130852

50 2997

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 2997  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Coyne

2. DATE  
OF  
DEATH

Mar. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Baltimore City Hospitals

4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore--Infirmery 2-03

D. STREET ADDRESS (If rural, give location)

913 Fell St.

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 10, 1878

9. AGE (In years  
last birthday)

72

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

CANNING

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Dudley Coyne

14. MOTHER'S MAIDEN NAME

Kate Crow

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Records\* B.C.H.--4940 Eastern Ave.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-6-\_\_\_\_\_, 19 49 to 3-29-\_\_\_\_\_, 1950, that I last saw the  
deceased alive on 3-29-\_\_\_\_\_, 1950, and that death occurred at 1:05 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Ave.

3-30-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

3/31/50

24C. NAME OF CEMETERY OR CREMATORY

SACRED HEART

24D. LOCATION (City, town, or county)

DUNDALK

(State)

MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

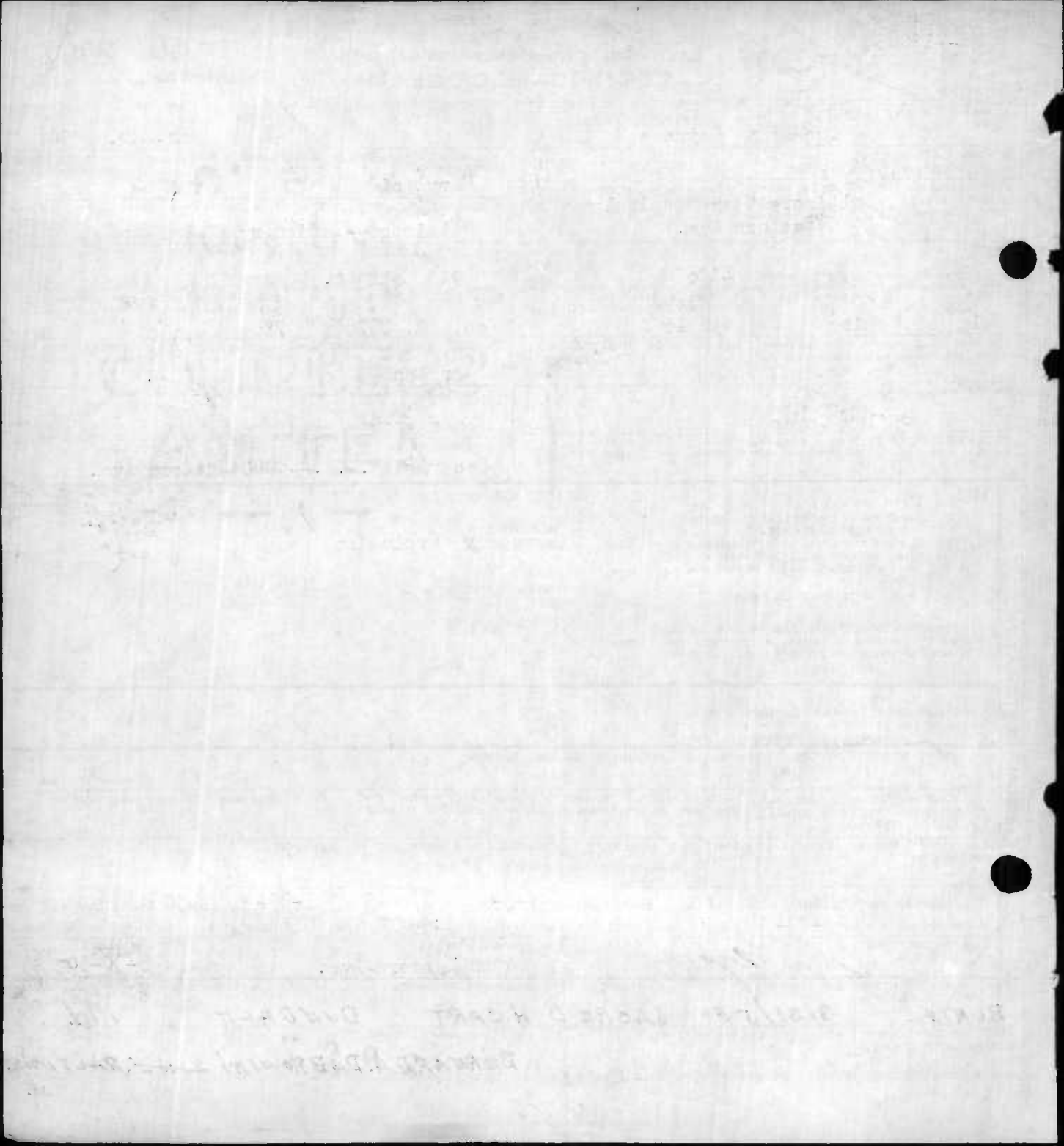
ADDRESS

MAR 31 1950

Huntington Williams

BERNARD A. DABROWSKI 211 E. BALTIMORE







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

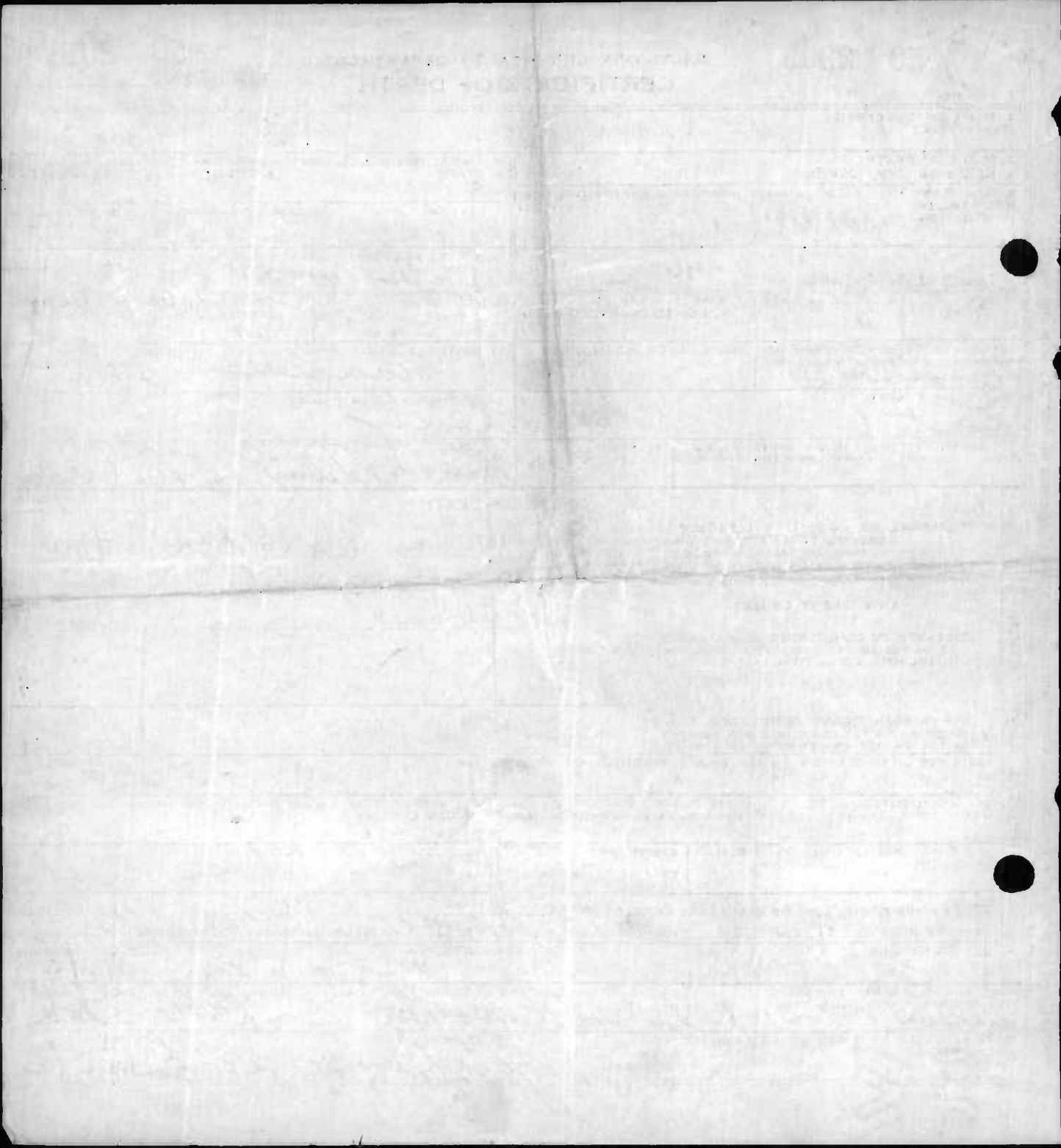
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ANNA KOLMAN</b>		2. DATE OF DEATH <b>3-30-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>West Belts General</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balti.</b>	
c. Length of stay in Baltimore <b>46</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>Lake Court Apartment B1 #17.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>70</b>
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lester</b>		14. MOTHER'S MAIDEN NAME <b>Rena</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Morris Kolman</b>		ADDRESS <b>257 Linden Ave</b>	

18. <b>491X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Granchopneumonia RLL &amp; RML.</b> DUE TO (B) <b>Adenoma of Thyroid.</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>unknown</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/21/50</b> , 19 <b>50</b> , to <b>3/30/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3/30/50</b> , 19 <b>50</b> , and that death occurred at <b>1300</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Joseph Sheen</b>		23B. ADDRESS <b>West Belts Gen</b>		23C. DATE SIGNED <b>3/30/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>3-31-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balti Md</b>		24E. FUNERAL DIRECTOR <b>Jack Lewis</b>		24F. ADDRESS <b>2100 Linden Ave</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 31 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>		25. FUNERAL DIRECTOR <b>Jack Lewis</b>	







300  
50 2999BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 2999

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEAH KITT

2. DATE  
OF  
DEATH

3-30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2476 Shirley Ave

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

STATE Md

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Mt Carmel Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 28-01

c. Length of stay in Baltimore

life

D. STREET ADDRESS (If rural, give location)

4502 Fernhill Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10a. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMY FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

14. MOTHER'S MAIDEN NAME

17. INFORMANT

ADDRESS

Rebecca Shapiro 4502 Fernhill Ave

18. 175 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

General Carcinomatosis

1 1/2 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Papillary-carcin. carcinoma of ovary

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from Feb 26 1950, to March 30, 1950, that I last saw the  
deceased alive on March 30, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Dr. Bernard Cohen

M. D.

-margaret, 208

3-31-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial 3-31-50

3-31-50

Hebrew Herring Run

Baltimore

Md

MAR 31 1950

margaret Williams, M.D.

Jack Lewis

2100 Eutar Rd



Remond Co  
Ma 400  
to 7462  
Marlborough



50 3000

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA MIZEROVSKY

2. DATE  
OF  
DEATH

March 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2101 Cold Spring Lane

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
INSTITUTION Cold Spring Con. Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE M.d B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
2106 E. Monument St.

c. Length of stay in Baltimore

55 years

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

May 16, 1870

9. AGE (In years last birthday)

79

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
housewife

10B. KIND OF BUSINESS OR INDUSTRY  
at home

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

James Mizzerovsky, son, 3026 Edgewood Ave.

18. 4500

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

GENERALIZED ARTERIOSCLEROSIS 15 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb - 15, 1946, to March 22, 1950, that I last saw the deceased alive on March 22, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Apr. 1, 1950

Oak Hill Cemetery

Horner's Lane, Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

26015-5 E. Madison St.

ADDRESS, Md.



